Anthem Blue Cross and Blue Shield
Anthem Silver Pathway X HMO 4250/30%

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

Coverage Period: 01/01/2016 – 12/31/2016

Coverage for: Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/sbc or by calling (855) 738-6671.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,250** person / **$8,500** family for In-Network Providers. Does not apply to Prescription Drugs, Preventive Care, Primary Care visit, Specialist visit, and Child Dental.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes; **$1,000** person / **$2,000** family for In-Network Providers Tier 2, Tier 3 and Tier 4 Prescription Drugs. There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes; **$5,250** person / **$10,500** family for In-Network Providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Pathway X HMO. For a list of In-Network providers, see www.anthem.com or call **(855) 738-6671**. Dental	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or

Important Questions	Answers	Why this Matters:
	and Vision benefits may access a different network of providers.	participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; you do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services.**

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

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	--------none--------
	Specialist visit	$50 copay per visit	Not covered	--------none--------
	Other practitioner office visit	Spinal Manipulation 30% coinsurance Acupuncture Not covered	Spinal Manipulation Not covered Acupuncture Not covered	Spinal Manipulation Coverage for In-Network Providers is limited to 12 visits per benefit period. Acupuncture --------none--------
	Preventive care/screening/immunization	No charge	Not covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 30% coinsurance X-Ray – Office 30% coinsurance	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	--------none--------
If you need drugs to treat your illness or condition	Tier1 - Typically Generic	$15 copay per prescription (retail only) and $30 copay	Not covered	Covers up to a 30 day supply (retail). Covers up to a 90 day supply

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ Anthem Select Drug List		per prescription (home delivery only)		(mail order). Coverage is limited to those Drugs listed on our Prescription Drug List (formulary). If you are taking a Maintenance Medication, you may get the first 30 day supply plus one additional 30 day refill of the same Maintenance Medication at your local Retail Pharmacy. You must then use the Mail Service Pharmacy.
	Tier2 - Typically Preferred / Brand	$40 copay per prescription (retail only) and $100 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail). Covers up to a 90 day supply (mail order). Coverage is limited to those Drugs listed on our Prescription Drug List (formulary). If you are taking a Maintenance Medication, you may get the first 30 day supply plus one additional 30 day refill of the same Maintenance Medication at your local Retail Pharmacy. You must then use the Mail Service Pharmacy.
	Tier3 - Typically Non-Preferred / Specialty Drugs	50% coinsurance (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail). Covers up to a 90 day supply

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				(mail order). Coverage is limited to those Drugs listed on our Prescription Drug List (formulary). If you are taking a Maintenance Medication, you may get the first 30 day supply plus one additional 30 day refill of the same Maintenance Medication at your local Retail Pharmacy. You must then use the Mail Service Pharmacy.
	Tier4 - Typically Specialty Drugs	50% coinsurance (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail). Covers up to a 30 day supply (mail order). Coverage is limited to those Drugs listed on our Prescription Drug List (formulary). Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	--------none--------
	Physician/surgeon fees	30% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	--------none--------
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-emergency ambulance/transportation out of network is not covered unless

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				authorized. Authorized out of network is limited to $50,000 per occurrence.
	Urgent care	$90 copay per visit	$90 copay per visit	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission and then 30% coinsurance	Not covered	--------none--------
	Physician/surgeon fee	30% coinsurance	Not covered	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $25 copay per visit	Mental/Behavioral Health Office Visit Not covered	Mental/Behavioral Health Office Visit --------none--------
	Mental/Behavioral health inpatient services	$500 copay per admission and then 30% coinsurance	Not covered	--------none--------
	Substance use disorder outpatient services	Substance Abuse Office Visit $25 copay per visit	Substance Abuse Office Visit Not covered	Substance Abuse Office Visit --------none--------
	Substance use disorder inpatient services	$500 copay per admission and then 30% coinsurance	Not covered	--------none--------
If you are pregnant	Prenatal and postnatal care	30% coinsurance	Not covered	--------none--------
	Delivery and all inpatient services	$500 copay per admission and then 30% coinsurance	Not covered	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Coverage for In-Network Providers is limited to 100 visits per benefit period.
	Rehabilitation services	Speech Therapy 30% coinsurance Physical Therapy/Occupational	Speech Therapy Not covered Physical Therapy/Occupational	Coverage for pulmonary rehabilitation is limited to 20 visits per benefit period, Speech Therapy

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		Therapy $25 copay per visit	Therapy Not covered	is limited to 20 visits per benefit period, Occupational Therapy is limited to 20 visits per benefit period, and Physical Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers.
	Habilitation services	Speech Therapy 30% coinsurance Physical Therapy/Occupational Therapy $25 copay per visit	Speech Therapy Not covered Physical Therapy/Occupational Therapy Not covered	Habilitation and Rehabilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	30% coinsurance	Not covered	Coverage for In-Network Providers is limited to 90 days per benefit period.
	Durable medical equipment	30% coinsurance	Not covered	--------none--------
	Hospice service	No charge	No charge	--------none--------
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage for In-Network Providers is limited to 1 exam per benefit period.
	Glasses	No charge	Not covered	Coverage for In-Network Providers is limited to 1 unit per benefit period and 1 additional unit if medically necessary.
	Dental check-up	10% coinsurance	Not covered	Limited to 2 visits per year.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Covered Services rendered by Providers located outside the Commonwealth of KY, unless the services are for Emergency Care, Urgent Care and ambulance services; or the services are approved in advance by Anthem.
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-Formulary drugs
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care Coverage is limited to 12 visits per benefit period.
- Hearing aids Coverage for left ear is limited to 1 unit every 36 months and right ear is limited to 1 unit every 36 months.
- Private-duty nursing Coverage is limited to 2,000 hours per benefit period.

Your Rights to Continue Coverage:

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

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

For more information on your rights to continue coverage, contact the insurer at (855) 738-6671. You may also contact your state insurance department at:

Department of Insurance
215 West Main Street
Frankfort, Kentucky 40601
(502) 564-3630
(800) 595-6053
(800) 648-6056

Your Grievance and Appeals Rights:

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

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

Department of Insurance
215 West Main Street
Frankfort, Kentucky 40601
(502) 564-3630
(800) 595-6053
(800) 648-6056

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>does</u> provide minimum essential coverage.**

Language Access Services:

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

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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

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

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,240
- **Patient pays** $5,300

Sample care costs:

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

Patient pays:

Deductibles	$4,300
Copays	$600
Coinsurance	$400
Limits or exclusions	$0
Total	$5,300

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,370
- **Patient pays** $3,030

Sample care costs:

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

Patient pays:

Deductibles	$1,500
Copays	$1,200
Coinsurance	$30
Limits or exclusions	$300
Total	$3,030

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call (855) 738-6671 or visit us at www.anthem.com

KY/I/F/Anthem Silver Pathway X HMO 4250/30%/1WZG/NA/01-16

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 738-6671 to request a copy.