

Summary of Benefits for Anthem Choice PPO Plan on Pathway PPO Network and PPO Network

This is a general benefit summary for this health plan. A complete listing and description of benefits, limitations, and exclusions are found in the Certificate. Copayment options reflect the amount the member will pay, coinsurance options reflect the amount that Anthem will pay. Any outpatient covered service not elsewhere listed in this summary of benefits, but otherwise eligible for coverage, will be paid by Anthem at the coinsurance after deductible level of benefit.

	In-Network (Pathway PPO Network Participating Provider)		In-Network (PPO Network Participating Provider)		Out-of-Network (Non-Participating Provider)	
Annual Deductible	Individual: \$750	Family: \$1,500	Individual: \$2,250	Family: \$4,500	Individual: \$4,500	Family: \$9,000
Deductibles are per calendar year. Deductibles apply only to specified services. Deductibles contribute toward the out-of-pocket annual maximum.		One member may not contribute any more than the individual deductible toward the family deductible.		One member may not contribute any more than the individual deductible toward the family deductible.		
					For non-participating providers, the member must pay the difference between the maximum allowed amount and the non-participating provider's billed charges, unless noted otherwise. Charges in excess of the maximum allowed amount do not count toward the satisfaction of the deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.	

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	In-Network (Pathway PPO Network Participating Provider)		In-Network (PPO Network Participating Provider)		Out-of-Network (Non-Participating Provider)	
Out-of-Pocket Annual Maximum All copayments, coinsurance and deductible amounts contribute to the out-of- pocket annual maximum except as follows: a) Out-of-network coinsurance amounts related to temporomandibular joint syndrome. b) Out-of-network coinsurance amounts related to human organ and tissue transplants. Some covered services have a maximum number of days, visits or dollar amounts. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.	Individual: \$6,500	Family: \$13,000	Individual: \$6,500	Family: \$13,000	Individual: \$13,000	Family: \$26,000
	combined in-network Pathway PPO network and PPO network.	combined in-network Pathway PPO network and PPO network.	combined in-network Pathway PPO network and PPO network.	combined in-network Pathway PPO network and PPO network.		
		One member may not contribute any more than the individual out-of- pocket annual maximum toward the family out- of-pocket annual maximum.		One member may not contribute any more than the individual out-of- pocket annual maximum toward the family out- of-pocket annual maximum.		One member may not contribute any more than the individual out-of- pocket annual maximum toward the family out- of-pocket annual maximum.
					The difference between billed charges and the maximum allowed amount for non- participating providers does not count toward the member's out-of- pocket maximum amount. Even once the out-of-pocket maximum is satisfied, the member will still be responsible for paying the difference between the maximum allowed amount and the non-participating provider's billed charges.	
Lifetime Maximum Benefit	No lifetime maximum.					
Other Applicable Maximums	Applied behavior analysis treatment for autism spectrum disorder is limited to a maximum benefit of 500 hours per year for members under 18 years of age or, if enrolled in high school, until the member reaches 22 years of age.					

Services	In-Network (Pathway PPO Network Participating Provider)	In-Network (PPO Network Participating Provider)	Out-of-Network (Non- Participating Provider)	Additional Information
1. Physician Visits				For laboratory, pathology and x-ray services performed in conjunction with a physician's office visit. See section 4 for payment information. Physician office visits include diabetic management and limited family planning services (see certificate for covered services).
a) Physician office visits and physician consultations	\$15 copayment per visit for PCP provider care and \$30 copayment per visit for specialists	\$45 copayment per visit for PCP provider care and \$90 copayment per visit for specialists	50% coinsurance after deductible	
b) Services related to physician office visit including but not limited to, allergy testing, allergy injections, or office surgeries	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
c) Inpatient physician visits	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
d) Online Care Visit	\$15 copayment per visit	\$15 copayment per visit	Not covered	
2. Retail Health Clinic				
a) Retail Health clinic visit	\$15 copayment per visit	\$15 copayment per visit	50% coinsurance after deductible	
b) Laboratory and Pathology performed in and billed by a Retail Health clinic	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
c) X-ray performed in and billed by a retail health clinic	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	

Services	In-Network (Pathway PPO Network Participating Provider)	In-Network (PPO Network Participating Provider)	Out-of-Network (Non- Participating Provider)	Additional Information
3. Preventive Care Preventive care services that meet the requirements of federal and state law including screenings, immunizations and office visits.	No charge	60% coinsurance after deductible	50% coinsurance after deductible	
4. Diagnostic Services, Laboratory, Pathology, and X-ray a) Laboratory and Pathology performed in and billed by a physician's office, urgent care center or independent /freestanding lab b) X-ray performed in a physician's office, urgent care center or freestanding facility c) Laboratory, Pathology, and X-ray performed in an outpatient facility d) MRI/MRA, PET, CT scans, nuclear medicine and other high tech services	80% coinsurance after deductible 80% coinsurance after deductible 80% coinsurance after deductible 80% coinsurance after deductible	60% coinsurance after deductible 60% coinsurance after deductible 60% coinsurance after deductible 60% coinsurance after deductible	50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible	
5. Maternity Care a) Prenatal care b) Delivery & inpatient baby care	\$150 copayment for the first prenatal care office visit/delivery from the physician 80% coinsurance after deductible	\$300 copayment for the first prenatal care office visit/delivery from the physician 60% coinsurance after deductible	50% coinsurance after deductible 50% coinsurance after deductible	For laboratory, pathology and x-ray services performed in conjunction with a physician's office visit. See section 4 for payment information. Limited to one routine ultrasound per pregnancy.

Services	In-Network (Pathway PPO Network Participating Provider)	In-Network (PPO Network Participating Provider)	Out-of-Network (Non- Participating Provider)	Additional Information
6. Outpatient Therapies: Physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and spinal manipulations/ acupuncture				
a) Outpatient physical therapy, occupational therapy, speech therapy and cardiac rehabilitation	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	Limited to 20 visits each of physical, occupational and speech therapy per member per year. Benefits are paid up to 36 visits for cardiac rehabilitation.
b) Outpatient spinal manipulations and acupuncture	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	Limited to 12 visits per member per year.
7. Hospital Care/Other Facility Services				
a) Inpatient	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	Limited to 30 inpatient days per member per year.
b) Inpatient – acute rehabilitation therapy	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
c) Outpatient Surgery	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
8. Emergency Care	80% coinsurance after deductible	80% coinsurance after deductible	80% coinsurance after deductible	Member cost share responsibility for Out-of-Network services will be the same as In-Network services.
9. Urgent Care				
Facility, urgent care center, or after hours at a physician office	\$30 copayment per visit	\$90 copayment per visit	50% coinsurance after deductible	For laboratory, pathology and x-ray services see section 4 for payment information.

Services	In-Network (Pathway PPO Network Participating Provider)	In-Network (PPO Network Participating Provider)	Out-of-Network (Non- Participating Provider)	Additional Information
10. Ambulance Services				
a) Ground Services	80% coinsurance after deductible	80% coinsurance after deductible	80% coinsurance after deductible	
b) Air and Water Services	80% coinsurance after deductible	80% coinsurance after deductible	80% coinsurance after deductible	Air and Water services are limited to a combined maximum benefit of \$5,000 per trip.
11. Mental Health and Substance Abuse Services				
a) Inpatient	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
b) Outpatient				
- Office visit/professional	\$15 copayment per visit	\$45 copayment per visit	50% coinsurance after deductible	
- Facility	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
12. Medical Supplies and Equipment	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	Includes diabetic supplies and equipment, medical supplies, durable medical equipment, oxygen and equipment, orthopedic appliances, prosthetic devices and other appliances.
13. Home Health Care	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	Limited to 100 visits per member per year
14. Chemotherapy, Hemodialysis, and Radiation Therapy				
a) Inpatient	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
b) Outpatient	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	

Services	In-Network (Pathway PPO Network Participating Provider)	In-Network (PPO Network Participating Provider)	Out-of-Network (Non- Participating Provider)	Additional Information
15. Skilled Nursing Facility	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	Limited to 100 inpatient days per member per year.
16. Hospice Care	No charge	No charge	50% coinsurance after deductible	
17. Human Organ and Tissue Transplants				See the certificate for details on covered transplants.
a) Inpatient	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	
b) Outpatient	\$15 copayment per visit for PCP provider care and \$30 copayment per visit for specialists	\$45 copayment per visit for PCP provider care and \$90 copayment per visit for specialists	50% coinsurance after deductible	Transportation and lodging services are limited to a maximum benefit of \$10,000 per transplant; unrelated donor searches for bone marrow and stem cells are limited to a maximum benefit of \$30,000 per transplant.
18. Temporomandibular Joint Syndrome				
a) Inpatient Surgery	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
b) Outpatient Surgery	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
c) Outpatient Physician Visits	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
19. Enteral Formula and Special Foods	80% coinsurance after deductible	60% coinsurance after deductible	50% coinsurance after deductible	Special food products that are prescribed or ordered by a physician as medically necessary are allowed.

Services		Additional Information
20. Prescription Drugs		
a) Outpatient Retail Pharmacy Drugs	<p>Tier 1 \$15 copayment per prescription, Tier 2 \$45 copayment per prescription, Tier 3 \$75 copayment per prescription, Tier 4 30% copayment per prescription, when received from a contracted pharmacy.</p> <p>50% copayment of the prescription drug maximum allowed amount per prescription for Tier 1, Tier 2, Tier 3 and Tier 4 prescription drugs when received from a non-contracted pharmacy.</p>	<p>Orally administered cancer chemotherapy drugs are covered according to state law.</p> <p>Available up to a 30-day supply.</p> <p>Tier 1, Tier 2, and Tier 3 non specialty maintenance drugs may be filled up to a 90 day supply at most retail pharmacy locations.</p> <p>A member is required to pay the retail pharmacy copayment for each 30 day supply.</p>
b) Home Delivery (Mail Order) Pharmacy Drugs	<p>Tier 1 \$37.50 copayment per prescription, Tier 2 \$135 copayment per prescription, Tier 3 \$225 copayment per prescription, Tier 4 30% copayment per prescription. Specialty pharmacy drugs are not available by home delivery (mail order).</p>	<p>Available through the Pharmacy Benefits Manager (PBM) home delivery (mail order) service up to a 90-day supply.</p>
c) Specialty Pharmacy Drugs	<p>Tier 1 \$15 copayment per prescription, Tier 2 \$45 copayment per prescription, Tier 3 \$75 copayment per prescription, Tier 4 30% copayment per prescription, when received from a contracted pharmacy.</p> <p>50% copayment of the prescription drug maximum allowed amount per prescription for Tier 1, Tier 2, Tier 3 and Tier 4 prescription drugs when received from a non-contracted pharmacy.</p> <p>The following applies to a), b) and c) above: For the Tier 4 outpatient retail pharmacy drugs or specialty pharmacy drugs, the maximum member copayment per prescription is \$500 per 30-day supply at a contracted pharmacy or from a contracted specialty pharmacy or a maximum member copayment per prescription of \$1000 per 30-day supply at a non-contracted pharmacy. For the Tier 4 non-specialty outpatient home delivery (mail order) pharmacy drugs, the maximum member copayment per prescription is \$1000 per 90-day supply via home delivery (mail order) service.</p> <p>Prescription drugs will always be dispensed as ordered by your provider and by applicable state</p>	<p>Available up to a 30-day supply. Specialty pharmacy drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. They are often unavailable at an outpatient retail pharmacy or home delivery (mail order) pharmacy since these drugs may require special handling such as temperature controlled packaging and overnight delivery. These specialty pharmacy drugs are available on an in-network basis from PBM or out-of-network at other specialty pharmacy</p>

Services		Additional Information
	<p>pharmacy regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your tier copayment of the generic drug. This cost difference does not contribute to the deductible or out-of-pocket annual maximum. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. For certain higher cost generic drugs, Anthem reserves the right, in our sole discretion, to make an exception and not require the member to pay the difference in cost between the generic and brand name drug. For drugs on our approved list, call the customer service phone number on the back of the member's ID card.</p>	<p>locations. If specialty pharmacy drugs are purchased from a retail pharmacy they are considered out-of-network for benefits since they are not consider services from the in-network PBM.</p>

Anthem Blue Cross and Blue Shield
Benefit Summary Disclosure Information
Anthem Choice
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This disclosure statement provides only a brief description of some important features and limitations of your policy. The certificate itself sets forth in the detail the rights and obligations of both you and the insurance company. It is important that you review the certificate once you are enrolled.

Coverage for treatment as part of a clinical trial:

Includes coverage for medical treatment provided in a Phase I, Phase II, Phase III or Phase IV clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome conducted in the state of Nevada.

Coverage for medical treatment is limited to:

- Any drug or device approved for sale by the Food and Drug Administration.
- The cost of any reasonably necessary health care services required from the medical treatment or complications thereof arising out of the medical treatment provided in the clinical trial.
- The initial consultation to determine whether the person is eligible to participate in a clinical trial.
- Health care services required for the clinically appropriate monitoring of the person during the clinical trial.

Coverage for the management and treatment of diabetes

Includes coverage for medication, equipment, supplies, and appliances that are medically necessary for the treatment of diabetes type I, type II, and gestational diabetes.

Coverage for self-management of diabetes, including:

- The training and education provided to a person covered under the contract after initial diagnosis of diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.
- Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the program of self-management of diabetes.
- Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

Medically Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem, subject to a member's right to appeal, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).

- Cost-effective compared to alternative interventions, including no intervention (“cost effective” does not mean lowest cost). It does mean that as to the diagnosis or treatment of the member’s illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member’s family or the provider.
- Not otherwise subject to an exclusion under the Certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary.

Maximum allowed amount

Reimbursement for services rendered by participating and non-participating providers is based on this health benefits plan maximum allowed amount for the covered service that the member receives.

NOTE: Anthem will apply the in network level of benefits and the member will not be required to pay more for the services than if the services had been received from a participating provider in the following circumstances:

- Emergency care (where rendered either within or outside the State of Nevada)
- Where in-patient hospital care at a non-participating hospital is necessary due to the nature of the treatment
- Where in-patient hospital care at a non-participating hospital is necessary due to participating provider hospital capacity
- When a member has received a preauthorized network exception

Emergency

Emergency means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the member, or
- Serious jeopardy to the health of an unborn child, or
- Serious impairment to bodily functions, or
- Serious and permanent dysfunction of any bodily organ or part.

Maximum Benefits

Some services or supplies may have an annual or lifetime maximum benefit, be sure to review you summary of benefits for further details on what services may have a maximum benefit.

Limitations and Exclusions

This plan does not cover some services. The plan includes limitations and exclusions to protect against duplicate or unnecessary services that could unfairly offset the cost of health care coverage for the entire plan. Following are examples of the plan’s limitations and exclusions (please consult your summary of benefits and the certificate for an exhaustive listing of exclusions and limitations):

- Benefits provided under any local, state, or federal laws, including Workers’ Compensation and Medicare
- Cosmetic surgery
- Services by a family member
- Weight-reduction services and medications
- Complications from non-covered services
- Our payment allowance will be reduced or denied from what would have been paid if pre-certification is not obtained prior to receiving inpatient hospital services and outpatient surgeries.

- Most services, such as non-emergency hospital admissions or surgical procedures require prior authorization.
- Alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), clonics or iridology.
- Artificial conception
- Services received before the effective date of coverage.
- Biofeedback.
- Chelating agents except for providing treatment for heavy metal poisoning.
- Services or supplies provided as part of clinical research, except where required by law or allowed by Anthem.
- Convalescent care
- Convenience, luxury, deluxe services or equipment. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters).
- Court ordered services unless those services are otherwise covered under the certificate.
- Custodial care.
- Dental services except for accident related dental services, dental anesthesia for children, temporomandibular joint therapy or surgery.
- Inpatient care received after the date Anthem, using managed care guidelines, determines discharge is appropriate.
- Hospital care if the member leaves a hospital against the medical advice of the physician, charges which are a direct result of the member's knowing and voluntary non-compliance of medically necessary care with prescribed medical treatment are not eligible for coverage.
- Domiciliary care such as care provided in residential, non-treatment institution, halfway house or school.
- Services and supplies already covered by other valid coverage.
- Experimental/Investigative procedures.
- Genetic counseling.
- Government operated facility such as a military medical facility or veterans administration facility unless authorized by Anthem.
- Hair loss, drugs, wigs, hairpieces, artificial hairpieces, hair or cranial prosthesis, hair transplants or implants even if there is a physician prescription, and a medical reason for the hair loss.
- Hearing aids or routine hearing tests.
- Hypnosis, whether for medical or anesthesia purposes.
- This coverage does not cover any loss to which a contributing cause was the member's commission of or attempt to commit a felony which they are convicted of.
- Therapies for learning deficiencies and/or behavioral problems.
- Maintenance therapy.
- Services and supplies that are not medically necessary.
- Charges for failure to keep a scheduled appointment.

- Neuropsychiatric testing.
- Non-covered providers who include but are not limited to:
 - Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
 - School infirmary.
 - Halfway house.
 - Massage therapist.
 - Nursing home.
 - Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.
- Non-medical expenses, including but not limited to:
 - Adoption expenses.
 - Educational classes and supplies not provided by the member's provider unless specifically allowed as a benefit under this certificate.
 - Vocational training services and supplies.
 - Mailing and/or shipping and handling expenses.
 - Interest expenses and delinquent payment fees.
 - Modifications to home, vehicle, or workplace regardless of medical condition or disability.
 - Membership fees for spas, health clubs, personal trainers, or other such facilities even if medically recommended, regardless of any therapeutic value.
 - Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
 - Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
 - Voice synthesizers or other communication devices, except as specifically allowed by Anthem's medical policy.
- Upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital imperfection or acquired characteristic.
- Any items available without a prescription such as over the counter items and items usually stocked in the home for general use including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This coverage does not cover laboratory test kits for home use. These include but are not limited to, home pregnancy tests and home HIV tests.
- Benefits are not provided for care received after coverage is terminated.
- Private duty nursing services.
- Private rooms are not covered.
- Charges for services and supplies when the member has received a professional or courtesy discount from a provider or where the member's portion of the payment is waived due or professional courtesy or discount.
- Peripheral bone density testing. This coverage does not cover the following except as described by medical policy screening or as provided in the certificate, whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy.
- Charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the provider when requested by the member.
- Services or supplies necessitated by injuries which a member intentionally self-inflicted, except where the law prohibits such an exclusion.

- Treatment of sexual dysfunction or impotence including all services, supplies or prescription drugs used for the treatment.
- Services and supplies which may be reimbursed by a third party
- Travel or lodging expenses for the member, member's family or the physician except as travel or lodging expenses related to human organ and tissue transplants.
- Routine eye examinations, routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which requires the use of contact lenses), or prescriptions for such services and supplies. Surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Vision therapy, including but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.
- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.
- Whole blood, blood plasma and blood derivatives received from community sources or replaced through donor credit.
- Bariatric surgery services.
- Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.
- Waived cost shares out-of-network. This coverage does not cover any service for which the member is responsible for under the terms of this certificate to pay a copayment, coinsurance or deductible, and the copayment, coinsurance or deductible is waived by an out-of-network provider.

Rate determinations

Rates are calculated based on allowable case characteristics of member age, geographic rating area, dependent enrollment, and tobacco use status.

Provider Directories

Copies of provider directories for all products offered by Anthem may be obtained by calling the customer service department or accessing the information on our Internet site at www.Anthem.com.

Provider Network

Under Anthem PPO plans, members choose physicians, hospitals and other health care providers from the Anthem Pathway PPO participating provider or PPO participating provider network. Using the PPO networks can mean substantial savings. When a member sees a Pathway PPO participating provider they have the lowest out-of-pocket cost requirements. When a member sees a PPO participating provider they may have a higher out-of-pocket cost requirement than if they had seen a Pathway PPO provider, however for many services the member will still have a lower out-of-pocket cost requirement than if they had seen a non-participating provider. The type of provider a member chooses (Pathway PPO participating providers, PPO participating providers, or non-participating providers) will determine the benefit level payable under this health benefit plan. If care is received outside the Pathway PPO participating provider or PPO participating provider network, the member may pay a higher deductible and coinsurance and charges over the Maximum Allowed Amount.

Broker Name, Address and Telephone Number (If applicable):
