Filing at a Glance

Company:	Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut
Product Name:	Individual 2017
State:	Connecticut
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005D Individual - HMO
Filing Type:	Rate
Date Submitted:	06/01/2016
SERFF Tr Num:	AWLP-130576957
SERFF Status:	Assigned
State Tr Num:	201603311
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2017
Author(s):	Tu Nguyen, John Bryson, Jeremy Chernofsky, Dickson Lee, Katie Wondergem, Matt Lindsey, Kristin Roberts
Reviewer(s):	Paul Lombardo (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: *Connecticut* **Filing Company:** *Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*

TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*

Product Name: *Individual 2017*

Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact: 26.8%

Deemer Date:
Submitted By: Katie Wondergem

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 06/01/2016
State Status Changed:
Created By: John Bryson
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Exchange Intentions:

This filing contains benefit plans to be sold through the CT Exchange and benefit plans to be sold Off the CT Exchange.

Filing Description:

June 1, 2016

Mr. Paul Lombardo, ASA, MAAA
Actuary, Life & Health Division
State of Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

Re: Anthem BCBS 2017 Individual Rate Filing
SERFF Tracking Number AWLP-130576957

Dear Mr. Lombardo:

For your approval, Anthem Blue Cross and Blue Shield (ABCBS) is submitting proposed premium rates for its new and renewing Individual Products for both On & Off the Connecticut Exchange, effective January 1, 2017.

Please see the enclosed files for the scope of changes and the supporting documents:

•Anthem Individual State - Actuarial Memorandum
•Anthem 2017 Actuarial Certification
•Anthem Individual Federal – Actuarial Memorandum
•Anthem 2017 Unified Rate Review Template
•Unique Plan Design Supporting Documentation
•Actuarial Value Screenshot for each Individual Plan
•Anthem 2017 Rates Template
•Anthem 2017 Schedule of Benefits

State: *Connecticut* **Filing Company:** *Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*

TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*

Product Name: *Individual 2017*

Project Name/Number: */*

All Individual products include pediatric dental benefits embedded in the benefits.

The individual rates are developed from the 2015 Individual ACA experience and this same experience data is used for the Claim Lag Triangle exhibit.

This filing includes estimates for the impact of risk adjustment based on input from Wakely Consulting. Anthem plans to adjust this filing if the results of the June update to those estimates are materially different. Anthem also plans to submit adjustments to this filing if CSR subsidies are eliminated.

Thank you for your attention to this filing. If you have any questions regarding this matter, please feel free to contact me at 203 677-8510. You may also email me at tu.nguyen@anthem.com.

Sincerely,

Tu Nguyen, FSA, MAAA
Director & Actuary III

Attachments

Company and Contact

Filing Contact Information

Tu Nguyen, Commercial NH
3000 Goffs Falls Rd
Manchester, NH 03111

tu.nguyen@anthem.com
603-695-7833 [Phone]

Filing Company Information

Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut
108 Leigus Road
Wallingford, CT 06492
(203) 677-4000 ext. [Phone]

CoCode: 60217
Group Code: 671
Group Name: WellPoint Inc Group
FEIN Number: 06-1475928

State of Domicile: Connecticut
Company Type: Life, Accident, Health
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

SERFF Tracking #:	*AWLP-130576957*	***State Tracking #:***	*201603311*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual 2017*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	Review & Approval
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	2.400%
Effective Date of Last Rate Revision:	01/01/2016
Filing Method of Last Filing:	Review & Approval

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut	Increase	26.800%	26.800%				%	%

Rate Review Detail

COMPANY:

Company Name: Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut

HHS Issuer Id: 86545

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
See Actuarial Memorandum Exhibit A			56700

Trend Factors: 9.6%

FORMS:

New Policy Forms: CT ON HIX HMO (1/17), CT OFF HIX HMO (1/17), CT ON HIX PPO (1/17), CT OFF HIX PPO (1/17)

Affected Forms:

Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual

Member Months: 680,400

Benefit Change: Increase

Percent Change Requested: Min: 16.5 Max: 39.8 Avg: 26.8

PRIOR RATE:

Total Earned Premium: 310,943,292.00

Total Incurred Claims: 246,400,182.00

Annual $: Min: 85.40 Max: 1,224.20 Avg: 471.10

REQUESTED RATE:

Projected Earned Premium: 392,941,786.00

Projected Incurred Claims: 326,394,684.00

Annual $: Min: 114.80 Max: 1,625.30 Avg: 577.50

SERFF Tracking #: AWLP-130576957 **State Tracking #:** 201603311 **Company Tracking #:**

State: Connecticut **Filing Company:** Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut

TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO

Product Name: Individual 2017

Project Name/Number: /

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Actuarial memorandum Exhibit A	CT ON HIX HMO (1/17), CT OFF HIX HMO (1/17), CT ON HIX PPO (1/17), CT OFF HIX PPO (1/17)	New		2017 Actuarial Memorandum - CT Individual Exhibit A (06-01-16).pdf,

Exhibit A - Non-Grandfathered Rate Changes

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

HIOS Plan Name	2017 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2016 HIOS Plan ID Mapping	Plan Category	Plan Specific Rate Change (excluding aging) {1}
Catastrophic HMO Pathway X Enhanced	86545CT1230005	On	Catastrophic	0.5556	Pathway X Enhanced	All	86545CT1230005	Renewing	31.3%
Bronze HMO Pathway X Enhanced	86545CT1230002	On	Bronze	0.7633	Pathway X Enhanced	All	86545CT1230002	Renewing	20.9%
Bronze HMO Pathway X Enhanced for HSA	86545CT1230001	On	Bronze	0.7516	Pathway X Enhanced	All	86545CT1230001	Renewing	28.3%
Gold HMO Pathway X Enhanced	86545CT1230004	On	Gold	1.0697	Pathway X Enhanced	All	86545CT1230004	Renewing	17.8%
Anthem HMO Catastrophic BlueCare 7150/0%	86545CT1310033	Off	Catastrophic	0.6385	BlueCare	All	86545CT1310033	Renewing	39.3%
Anthem Bronze HMO BlueCare 6200/12400/0% for HSA	86545CT1310019	Off	Bronze	0.8697	BlueCare	All	86545CT1310019	Renewing	35.0%
Anthem Silver HMO BlueCare 3850/0%	86545CT1310031	Off	Silver	0.9551	BlueCare	All	86545CT1310031	Renewing	16.5%
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	86545CT1310030	Off	Silver	0.9981	BlueCare	All	86545CT1310030	Renewing	27.0%
Anthem Silver HMO BlueCare Tiered 3550/6400/0%	86545CT1310042	Off	Silver	0.9289	BlueCare Tiered	All	86545CT1340014	New	28.3%
Anthem Gold HMO BlueCare 1500/0%	86545CT1310032	Off	Gold	1.2283	BlueCare	All	86545CT1310032	Renewing	24.4%
Anthem Gold HMO BlueCare Tiered 1650/3300/0%	86545CT1310041	Off	Gold	1.2904	BlueCare Tiered	All	None	New	0.0%
Bronze PPO Standard Pathway X	86545CT1330002	On	Bronze	0.7512	Pathway X	All	86545CT1330002	Renewing	18.9%
Bronze PPO Standard Pathway X for HSA	86545CT1330009	On	Bronze	0.7655	Pathway X	All	86545CT1330009	Renewing	33.5%
Silver PPO Pathway X	86545CT1330004	On	Silver	1.0254	Pathway X	All	86545CT1330004	Renewing	20.9%
Silver PPO Standard Pathway X	86545CT1330001	On	Silver	1.0234	Pathway X	All	86545CT1330001	Renewing	23.2%
Silver Core PPO Pathway X 5300	86545CT1330010	On	Silver	1.0238	Pathway X	All	None	New	0.0%
Gold PPO Standard Pathway X	86545CT1330003	On	Gold	1.3679	Pathway X	All	86545CT1330003	Renewing	35.9%
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	86545CT1340005	Off	Bronze	0.8149	Century Preferred	All	86545CT1340005	Renewing	39.4%
Anthem Bronze PPO Century Preferred 7150/0%	86545CT1340010	Off	Bronze	0.7731	Century Preferred	All	86545CT1340010	Renewing	39.8%
Anthem Silver PPO Century Preferred 2750	86545CT1340006	Off	Silver	0.9847	Century Preferred	All	86545CT1340006	Renewing	22.5%
Anthem Silver PPO Century Preferred 3000/6000 for HSA	86545CT1340011	Off	Silver	0.9655	Century Preferred	All	86545CT1340011	Renewing	29.8%
Anthem Gold PPO Century Preferred 1500/4500 for HSA	86545CT1340012	Off	Gold	1.1829	Century Preferred	All	86545CT1340012	Renewing	23.5%
Anthem Gold PPO Century Preferred 1900/0%	86545CT1340013	Off	Gold	1.3611	Century Preferred	All	86545CT1340013	Renewing	33.4%
Gold HMO Pathway X Enhanced, a Multi-State Plan	86545CT1470002	On	Gold	1.0864	Pathway X Enhanced	All	86545CT1470002	Renewing	27.3%
Silver PPO Pathway X, a Multi-State Plan	86545CT1480002	On	Silver	1.0249	Pathway X	All	86545CT1480002	Renewing	21.5%

NOTES:

{1} Plan level increases in rates do not include demographic changes in the population.

SERFF Tracking #:	*AWLP-130576957*	***State Tracking #:***	*201603311*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual 2017*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2017 Actuarial Memorandum CT IND State (6-1-16).pdf
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Not needed at this time.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	2017 Actuarial Memorandum CT IND Federal (6-1-16).pdf Anthem Actuarial Certification (6-1-16).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	URRT-CT-IND1-86545-1Q17 - Submission 05 31 2016.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unique Plan Justifications
Comments:	
Attachment(s):	CT Anthem Individual 2017 Unique Plan Justification Sets (6-1-16).pdf
Item Status:	
Status Date:	

Satisfied - Item:	AV Screenshots
Comments:	
Attachment(s):	CT Anthem Individual 2017 Plan AVs (6-1-16).pdf
Item Status:	

SERFF Tracking #:	*AWLP-130576957*	***State Tracking #:***	*201603311*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual 2017*		
Project Name/Number:	*/*		

Status Date:	

Satisfied - Item:	Rate Template
Comments:	
Attachment(s):	1Q17_CT_86545_IND_On-Off_All-Plans_RateTables (6-1-16).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Summary of Benefits
Comments:	
Attachment(s):	CT Anthem Individual 2017 Summary of Benefits (6-1-16).pdf
Item Status:	
Status Date:	

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Anthem Health Plans, Inc.
State:	Connecticut
HIOS Issuer ID:	86545
NAIC Company Code:	60217
Market:	Individual
Effective Date:	January 1, 2017

- Company Contact Information

Primary Contact Name:	Tu Nguyen
Primary Contact Telephone Number:	(203) 677-8510
Primary Contact Email Address:	Tu.Nguyen@anthem.com

2. Scope and Purpose of the Filing

This is a rate filing for the Individual market ACA-compliant plans offered by Anthem Health Plans, Inc., also referred to as Anthem. The policy forms associated with these plans are listed below. The proposed rates in this filing will be effective for the 2017 plan year beginning January 1, 2017, and apply to plans both On-Exchange and Off-Exchange.

The Memorandum provides support to the rate development and demonstrates that rates are established in compliance with state laws and provisions of the Affordable Care Act. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):

CT ON HIX HMO (1/17)
CT OFF HIX HMO (1/17)
CT ON HIX PPO (1/17)
CT OFF HIX PPO (1/17)

3. Proposed Rate Increase(s)

The proposed annual rate changes by product in this filing range from 21.5% to 32.4%, with rate changes by plan from 16.5% to 39.8%. These ranges are based on the renewing plans, and are consistent with what's reported in the Unified Rate Review Template. Exhibit A shows the rate change for each plan.

Factors that affect the rate changes for all plans include:

- Emerging experience different than projected.
- Trend: This includes the impact of inflation, provider contracting changes, and increased utilization of services.
- Morbidity: There are anticipated changes in the market-wide morbidity of the covered population in the projection period.
- Benefit modifications, including changes made to comply with updated AV requirements.
- Changes in taxes, fees, and some non-benefit expenses, including the one-year suspension of the Health Insurer Tax for 2017.
- Discontinuance of the Federal Transitional Reinsurance Program, which impacts both payments from and contributions to the program.

Although rates are based on the same claims experience, the rate changes vary by plan due to the following factors:

- Changes in benefit design that vary by plan.
- Updates in benefit relativity factors among plans.
- Updated adjustment factors for catastrophic plans.
- Changes in some non-benefit expenses.
- Changes in the claim cost relativity by area.

4. Experience Period Premium and Claims

The experience period premium and claims reported in Worksheet 1, Section I of the Unified Rate Review Template (URRT) are for the non-grandfathered, single risk pool compliant policies of the identified legal entity in the Individual market.

• Paid Through Date

The experience reported in Worksheet 1, Section I of the URRT reflect the incurred claims from January 1, 2015 through December 31, 2015 based on claims paid through March 31, 2016.

- Premiums (net of MLR Rebate) in Experience Period

  The earned premium prior to MLR rebate is $298,699,430. The earned premium reflects the pro-rata share of premium based on policy coverage dates, and includes expected risk adjustments for the experience period.

  The preliminary MLR rebate estimate is $0, which is consistent with Anthem's December 31, 2015 general ledger estimate allocated to the non-grandfathered portion of Individual business. This is an estimated amount and will not be final until 7/31/2016. Using this MLR estimate, the net earned premium is $298,699,430 for the legal entity as reported in cell F14 of Worksheet 1, Section I of the URRT.

- Allowed and Incurred Claims Incurred During the Experience Period

  The allowed claims are determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

  Allowed and incurred claims are completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of cumulative claims paid of the ultimate incurred amounts for each lag month. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

  Allowed and incurred claims reported in Worksheet 1, Section I of the URRT are $351,107,881 and $279,876,943, respectively. Exhibit B provides claims detail.

  Exhibit S details historical experience for the policy forms included in this filing.

- Consistency with most recent financial statements

  Anthem reconciles its internal source systems monthly to ensure consistency with reported financials. Please note that the products contained in this filing are only a part of the total business reported on the financial statements. In addition, there are timing differences and certain definitional differences in the statutory statements compared to emerging experience utilized in this filing.

5. Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the URRT is as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, and dental services.
- Capitation: Includes all services provided under one or more capitated arrangements.
- Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

6. Projection Factors

The experience period claims in Worksheet 1, Section I of the URRT are projected to the projection period using the factors described below. Exhibit C provides a summary of the factors.

• Changes in the Morbidity of the Population Insured

Adjustments are made to account for the differences between the average morbidity of the experience period population and that of the anticipated population in the projection period.

The projected population consists of expected retention of existing policies and new sales. The new sales include the previously uninsured population and previously insured populations from other carriers or coverage. The morbidity impacts of population movement are based on the experience period risk score data and estimated risk scores of the projected population. Exhibit E shows the morbidity factor.

- Changes in Benefits

Changes in benefits include the following items. Exhibit E shows each adjustment factor.

- Essential Health Benefit (EHB) Changes: Adjustments are made to reflect the 2017 requirement to provide separate but equal visit limits for rehabilitative and habilitative therapies per HHS Notice of Benefit and Payment Parameters.

- Changes in Demographics (Normalization)

The experience period claims are normalized to reflect anticipated changes in age/gender, area, network, and benefit plan in the projection period. Exhibit D provides detail of each normalization factor below:

- Age/Gender: The assumed claims cost is applied by age and gender to the experience period membership distribution and the projection period membership distribution.
- Area/Network: The area claims factors are developed based on an analysis of allowed claims by network, mapped to the prescribed rating areas using the subscriber's 5-digit zip code.
- Benefit Plan: The experience period claims are normalized to reflect the average benefit level in the projection period using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

- Other Adjustments

Other adjustments to the experience claims data include the following items. Exhibit E and Exhibit F show the factors used for each adjustment.

- Change in Medical Management: This adjustment reflects the medical management costs not already included in the claims experience and trend.
- Induced Demand Due to Cost Share Reductions: Individuals who fall below 250% of the Federal Poverty Level and enroll in On-Exchange silver plans will be eligible for cost share reductions. The percentage of enrollment in CSR Plans in the experience period is compared to that of the projection period to adjust for the different induced demand level due to CSR between the two periods.
- Grace Period: The claims experience has been adjusted to account for incidences of enrollees not paying premiums due during the first month of the 90-day grace period when the QHP is liable for paying claims.

- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.
- Projected cost of pediatric dental and vision benefits are included on all plans. The "Silver Core PPO Pathway X 5300" plan (HIOS ID: 86545CT1330010) also includes the projected cost of offering adult vision benefits.
- Benefits in excess of the essential health benefits in the projection period are included. Exhibit F provides details of additional non-EHB benefits.

• Trend Factors (cost/utilization)

- The annual pricing trend used in the development of the rates is 9.6%. Consistent with prior Individual ACA Rate Filings, the Individual pricing trend is developed by normalizing historical Small Group benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend, recognizing recent emerging unfavorable trend experience. Examples of such changes include contracting, cost of care initiatives, workdays, costs associated with Hepatitis C, compound drugs, average wholesale price, and expected introduction of generic drugs. The trend includes a volatility provision in accordance with Actuarial Standards of Practice. For projection, the experience period claims are trended 24.1 months from the midpoint of the experience period, which is June 28, 2015, to the midpoint of the projection period, which is July 1, 2017. Exhibit E has details.
- Projected trends include the estimated cost of the pharmaceutical Harvoni and other high-cost drugs for treating Hepatitis C. These cost estimates were based on Connecticut Individual claims experience, together with CDC recommendations, Industry and Anthem Inc. data.

7. Credibility Manual Rate Development

The experience period claims are 100% credible based on the credibility method used. Therefore, a manual rate was not used in the rate development.

8. Credibility of Experience

• Credibility Method Used

Based on an analysis of historical data, the standard for fully credible experience is 6,780 members.

To determine credibility, the following formula was used: $\sqrt{\frac{\text{Experience Period Members}}{6{,}780}}$

• Resulting Credibility Level Assigned to Base Period Experience

With 52,434 members, the credibility level assigned to the experience period claims is 100%.

9. Paid to Allowed Ratio

The 'Paid to Allowed Average Factor in Projection Period' reported in Worksheet 1, Section III of the URRT is equal to the ratio of member weighted average paid claims PMPM by plan to the member weighted average allowed claims PMPM by plan for the essential health benefits. The projected membership by plan used in the weighted average is reported in Worksheet 2, Section II of the URRT.

10. Risk Adjustment and Reinsurance

- Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:

  Experience period risk adjustments are estimated based on available 2015 information, including Wakely market study, CMS preliminary 2015 risk adjustment transfers and additional analysis of the market risk. Wakely Consulting collected demographic and risk information from carriers in the state and market, and calculated Anthem's relative risk to the market. The 'Net Amt of Risk Adj' reported in Worksheet 2, section III of the URRT reflect the risk adjustment transfers net of risk adjustment fees.

  Experience period reinsurance recoveries are estimated by applying the 2015 federal reinsurance parameters to member level incurred claims of the experience period. The 'Net Amt of Rein' reported in Worksheet 2, section III of the URRT reflect the reinsurance recoveries net of reinsurance contributions.

- Projected Risk Adjustments PMPM:

  Projection period risk adjustments are estimated based on the HHS payment transfer formula. The Wakely study and CMS preliminary 2015 risk adjustment transfers were used to develop the assumptions for the market level risk scores and the company's relative risk to the market. Any projected changes in population movements and demographics that may affect risk adjustments are also considered.

  The projected risk adjustment PMPMs reported in the URRT are net of risk adjustment fees, and on a paid claim basis. The projected amount applied to the development of Market Adjusted Index Rate is on an allowed claim basis. Exhibit C and Exhibit G provide details.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

  Beginning in 2017, the Federal reinsurance program will no longer be in effect. The projected reinsurance amount will be $0.

11. Non-Benefit Expenses and Profit & Risk

Non-benefit expenses and profit & risk margin are explained below. Exhibit H shows the amount for each component.

- Administrative Expense

  Administrative Expenses are expected to be consistent with historical levels and are developed utilizing the same methodology as previous filings. Maintenance costs are projected for 2017 based on 2015 actual expenses with adjustments made for expected changes in business operations.

- Quality Improvement Expense

  Quality Improvement initiatives include programs such as Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, and Health Information Technology Expenses for Health Care Quality Improvements. The expense assumptions are based on historical expense level adjusted for cost inflation and anticipated changes in the programs.

- Selling Expense

  Selling Expense represents projected broker commissions and bonuses associated with the broker distribution channel. Commissions will be paid for Off-Exchange plans but will not be paid for On-Exchange plans. Commission will be paid only for members enrolling during the Open Enrollment period.

- Specialty Expenses

  Specialty Expenses are projected administrative expenses for dental and vision coverage.

- Miscellaneous Item

  The miscellaneous items represent DOI fees and assements, including the assessment from the State of Connecticut to cover the cost of the Vaccine Immunization Program and the DPH assessment.

- Taxes and Fees

  - Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund.
  - ACA Insurer Fee: The health insurance industry is assessed a permanent fee, based on market share of net premium, which is not tax deductible. The tax impact of non-deductibility is captured in this fee. For 2017, this fee is 0% due to a one-year suspension by the federal government.
  - Exchange User Fee: The Exchange User Fee applies to Exchange business only, but the cost is spread across all plans in the market. The expected charge is estimated at 1.65% of premium. The resulting fee/percentage is applied evenly to all plans in the risk pool, both On and Off Exchange.

    The Exchange User Fee is applied as an adjustment to the Market Adjusted Index Rate at the market level as shown in Exhibit C.

  - Premium taxes, federal income taxes, and state income taxes are also included.

  The Risk Adjustment User Fee is reflected in the risk adjustment component of incurred claims, therefore not included in taxes and fees.

- Profit & Risk Margin

  Profit & risk margin is reflected on a post-tax basis as a percentage of premium.

12. Projected Loss Ratio

- Projected Federal MLR

  Exhibit I shows the projected Federal MLR for the products in this filing. The calculation is an estimate and is not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only a subset of Anthem's Individual business. The MLR for Anthem's entire book of Individual business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

13. Single Risk Pool

The single risk pool for this filing is established according to the requirements in 45 CFR 156.80. It reflects all covered lives for every non-grandfathered product/plan combination sold in the Connecticut Individual market by Anthem Health Plans, Inc.

14. Index Rate

- Experience Period Index Rate

  The experience period Index Rate is equal to the allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. The Index Rate reported in Worksheet 1, Section I, cell G17 of the URRT is $558.00, rounded to the nearest whole dollar as instructed. No benefits in excess of the essential health benefits have been included in this amount.

- Projection Period Index Rate

  The projection period Index Rate is equal to projected allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. It reflects the anticipated claim level of the projection period including impact from trend, benefit and demographics as described in Section 6 of this memo.

  The projected index rate is reported in Worksheet 1, Section III, cell V44 of the URRT and is also shown in Exhibit C. No benefits in excess of the essential health benefits have been included in this amount.

15. Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules. The three market-wide adjustments - Federal reinsurance program adjustment (ended for 2017), risk adjustment and Exchange user fee adjustment - were described previously in the memo. In compliance with URR Instructions, these adjustments were applied on an allowed basis in the development of the Market Adjusted Index Rate, while they were reported in the URRT on a paid basis. Exhibit C illustrates the development of the Market Adjusted Index Rate.

16. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. Exhibit J shows the development. The plan level modifiers are described below:

- AV and Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan, based on the AV metal value with an adjustment for utilization differences due to differences in cost sharing.
- Provider Network Adjustments: This is a multiplicative factor that adjusts for differences in projected claims cost due to different network discounts.
- Adjustments for Benefits in Addition to the Essential Health Benefits: This multiplicative factor adjusts for additional non-EHB benefits shown in Exhibit F.
- Catastrophic Plan Adjustment: This adjustment reflects the projected costs of the population eligible for catastrophic plans. The catastrophic adjustment factor is applied to catastrophic plans only; all other plans have an adjustment factor of 1.0.
- Adjustments for Distribution and Administrative Cost: This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H, with the exception of the Exchange user fee. The Exchange user fee has been included in the Market Adjusted Index Rate at the market level.

Experience Period Plan Adjusted Index Rate

The Plan Adjusted Index Rates for the experience period are reported in Worksheet 2, Section III of the URRT. They represent the Plan Adjusted Index Rates filed in 2015.

17. Calibration

The Plan Adjusted Index Rate is calibrated by the Age and Geographic factors so that the schedule of premiums rates for each plan can be further developed. Exhibit K shows both calibration factors.

• Age Curve Calibration

The age factors are based on the Default Federal Standard Age Curve. The age calibration adjustment is calculated as the member weighted average of the age factors, using the projected membership distribution by age, with an adjustment for the maximum of 3 child dependents under age 21. Under this methodology, the approximate average age rounded to the nearest whole number for the risk pool is 48.

- Geographic Factor Calibration

  The geographic factors are developed from historical claims experience. The geographic calibration adjustment is calculated as the member weighted average of the geographic factors, using the projected membership distribution by area.

18. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated by calibrating the Plan Adjusted Index Rate by the Age and Geographic calibration factors described above, and applying consumer specific age and geographic rating factors. Exhibit N has the sample rate calculations.

19. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values reported in Worksheet 2, Section I of the URRT are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. When applicable, benefits for plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

20. Actuarial Value Pricing Values

The Actuarial Value (AV) Pricing Values for each plan are reported in Worksheet 2, Section I of the URRT. The AV Pricing Value represents the cumulative effect of adjustments made to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate. Consistent with final Market Rules, utilization adjustments are made to account for member behavior variations based upon cost-share variations of the benefit design and not the health status of the member. The plan level allowable modifiers to the Index Rate are included in Exhibit J and described in Section 16 above.

21. Membership Projections

Membership projections are reported in Worksheet 2, Section IV of the URRT. They are based on historical and current enrollment, and expected new sales and lapses.

For Silver level plans in the Individual market, the portion of projected membership that will be eligible for cost-sharing reduction subsidies at each subsidy level are estimated from the enrollment data in the experience period. Exhibit O provides projected distributions for each plan.

22. Terminated Plans and Products

Exhibit P provides a listing of 2015 and 2016 plans that will be terminated prior to January 1, 2017. The mapping of terminated plans to the new plans is also included.

23. Plan Type

The plan type for each plan reported in Worksheet 2, Section I of the URRT is consistent with the option chosen from the drop-down box.

24. Warning Alerts

There are warning alerts in cell A57 on Worksheet 2, Section III of the Unified Rate Review Template. This is because the Plan Adjusted Index Rates on Worksheet 2 are based on the distribution of ages, geography, and benefits that was projected when developing rates versus the Worksheet 1 average premium rate which reflects what actually emerged.

There are warning alerts in cells A68 and A73 on Worksheet 2, Section III of the Unified Rate Review Template. This is because Risk Adjustment receivable/payables and Reinsurance receivables for the experience period are not reflected in the Incurred Claims in Worksheet 1, but are reflected in the Incurred Claims in Worksheet 2, as directed in the URRT Instructions.

25. Tiered-Network Benefit Plans

The 2017 Individual plan portfolio contains two plans with tiered in-network benefits. These plans have up to three networks of provider care and different cost share provisions for each network:

- The Tier 1 network is a subset of preferred in-network providers; members have the lowest cost share amounts when utilizing this preferred network.
- The Tier 2 network is comprised of the remaining in-network providers and has higher cost share amounts compared to the Tier 1 network.
- For tiered PPO plans, the Tier 3 network is comprised of the out-of-network providers and has the highest cost share amounts.

Additional cost of care savings are expected from increased utilization of Tier 1 providers. These savings are used to reduce the tiered plan rate compared to a non-tiered plan with similar cost share provisions.

26. Effective Rate Review Information

The RBC Ratio for Anthem Health Plans, Inc. is 572.85% as of 12/31/2015.

Current capital and surplus for Anthem Health Plans, Inc. is $284,114,721 as shown on page 5, line 49 of the 2015 Annual Statement.

27. State Actuarial Memorandum Requirements

Supplemental material to satisfy the 2017 filing requirement notices issued on March 7, 2016 is included below.

The proposed retention charge in the rate development is 16.9%. This is comprised of both fixed and variable expenses and includes selling expense, administrative expense, federal fees, federal income tax, exchange fees and risk and net profit margin. The December 31, 2015 Annual Statement for Anthem Health Plans, Inc. has a retention amount of 22.4%. This amount is calculated from the Analysis of Operations by Lines of Business exhibit on page 7: 1 – [line 17, column 2 $791,038,042 / line 7, column 2 $1,018,886,075] = 22.4%.

Exhibit Q details Anthem's unit cost trend, utilization trend, technology trend, and other trend components.

Benefit buy-down analysis and impact on trend: No explicit buy-down impact was used in the rate development.

Bulletin HC-102 removed the age limit on hearing aid benefits. The expected cost of this change is an additional $0.34 claims PMPM during the 2017 rating period, which is not included in the 2015 experience period. The $0.34 PMPM represents 75% of the expected $0.45 impact of the Oct15 benefit mandate that removed age limits on hearing aids, which was included in the approved 2016 rate filing.

Bulletin HB-5233 requires health insurance coverage for mammograms provided by breast tomosynthesis. Anthem considers this coverage as a new mandate for 2017. The expected cost of this coverage has been considered but no adjustment to the rates has been made to cover the expected increase in cost at this time.

Bulletin HC-104 removed the age limit on infertility benefits. The expected cost of this change is an additional $0.25 claims PMPM during the 2017 rating period, which is not included in the 2015 experience period. The $0.25 represents 100% of the expected impact of the Jan16 benefit mandate that removed age limits on infertility benefits, which was included in the approved 2016 rate filing.

Exhibit R shows the claim lag triangle for the experience data.

The Annual Certification for substituting non-dollar limits on an essential health benefit can be found in Exhibit T.

The Annual Certification for compliance with Mental Health Parity Regulation can be found in Exhibit U.

Appendix A in conjunction with Exhibit A show a summary of the requested rate changes.

28. Reliance

In support of this rate development, various data and analyses were provided by other members of Anthem's actuarial staff, including data and analysis related to cost of care, valuation, and pricing. I have reviewed the data and analyses for reasonableness and consistency. I have relied on Wakely Consulting to provide the actuarial certification for the Unique Plan Design Supporting Documentation for the On Exchange Standard plans required by the Connecticut state exchange. I have also relied on Michele Archer, FSA, MAAA to provide the actuarial certification for the Unique Plan Design Supporting Documentation and Justification for plans included in this filing.

29. Actuarial Certification

I, Tu Nguyen, FSA, MAAA, am an actuary for Anthem. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The projected Index Rate is:

- In compliance with all applicable state and Federal statutes and regulations (45 CFR 156.80 and 147.102)
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Not excessive nor deficient

(2) The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 156.80(d)(2) were used to generate plan level rates.

(3) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV of the Part I Unified Rate Review Template is calculated in accordance with Actuarial Standards of Practice.

(4) The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

(5) The most recent AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate changes, for certification of Qualified Health Plans for Federally-Facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, used consistently, and only adjusted by the allowable modifiers. However, this Actuarial Memorandum does accurately describe the process used by the issuer to develop the rates.

Tu Nguyen, FSA, MAAA
Director & Actuary III

June 1, 2016
Date

Exhibit A - Non-Grandfathered Rate Changes

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

HIOS Plan Name	2017 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2016 HIOS Plan ID Mapping	Plan Category	Plan Specific Rate Change (excluding aging) {1}
Catastrophic HMO Pathway X Enhanced	86545CT1230005	On	Catastrophic	0.5556	Pathway X Enhanced	All	86545CT1230005	Renewing	31.3%
Bronze HMO Pathway X Enhanced	86545CT1230002	On	Bronze	0.7633	Pathway X Enhanced	All	86545CT1230002	Renewing	20.9%
Bronze HMO Pathway X Enhanced for HSA	86545CT1230001	On	Bronze	0.7516	Pathway X Enhanced	All	86545CT1230001	Renewing	28.3%
Gold HMO Pathway X Enhanced	86545CT1230004	On	Gold	1.0697	Pathway X Enhanced	All	86545CT1230004	Renewing	17.8%
Anthem HMO Catastrophic BlueCare 7150/0%	86545CT1310033	Off	Catastrophic	0.6385	BlueCare	All	86545CT1310033	Renewing	39.3%
Anthem Bronze HMO BlueCare 6200/12400/0% for HSA	86545CT1310019	Off	Bronze	0.8697	BlueCare	All	86545CT1310019	Renewing	35.0%
Anthem Silver HMO BlueCare 3850/0%	86545CT1310031	Off	Silver	0.9551	BlueCare	All	86545CT1310031	Renewing	16.5%
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	86545CT1310030	Off	Silver	0.9981	BlueCare	All	86545CT1310030	Renewing	27.0%
Anthem Silver HMO BlueCare Tiered 3550/6400/0%	86545CT1310042	Off	Silver	0.9289	BlueCare Tiered	All	86545CT1340014	New	28.3%
Anthem Gold HMO BlueCare 1500/0%	86545CT1310032	Off	Gold	1.2283	BlueCare	All	86545CT1310032	Renewing	24.4%
Anthem Gold HMO BlueCare Tiered 1650/3300/0%	86545CT1310041	Off	Gold	1.2904	BlueCare Tiered	All	None	New	0.0%
Bronze PPO Standard Pathway X	86545CT1330002	On	Bronze	0.7512	Pathway X	All	86545CT1330002	Renewing	18.9%
Bronze PPO Standard Pathway X for HSA	86545CT1330009	On	Bronze	0.7655	Pathway X	All	86545CT1330009	Renewing	33.5%
Silver PPO Pathway X	86545CT1330004	On	Silver	1.0254	Pathway X	All	86545CT1330004	Renewing	20.9%
Silver PPO Standard Pathway X	86545CT1330001	On	Silver	1.0234	Pathway X	All	86545CT1330001	Renewing	23.2%
Silver Core PPO Pathway X 5300	86545CT1330010	On	Silver	1.0238	Pathway X	All	None	New	0.0%
Gold PPO Standard Pathway X	86545CT1330003	On	Gold	1.3679	Pathway X	All	86545CT1330003	Renewing	35.9%
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	86545CT1340005	Off	Bronze	0.8149	Century Preferred	All	86545CT1340005	Renewing	39.4%
Anthem Bronze PPO Century Preferred 7150/0%	86545CT1340010	Off	Bronze	0.7731	Century Preferred	All	86545CT1340010	Renewing	39.8%
Anthem Silver PPO Century Preferred 2750	86545CT1340006	Off	Silver	0.9847	Century Preferred	All	86545CT1340006	Renewing	22.5%
Anthem Silver PPO Century Preferred 3000/6000 for HSA	86545CT1340011	Off	Silver	0.9655	Century Preferred	All	86545CT1340011	Renewing	29.8%
Anthem Gold PPO Century Preferred 1500/4500 for HSA	86545CT1340012	Off	Gold	1.1829	Century Preferred	All	86545CT1340012	Renewing	23.5%
Anthem Gold PPO Century Preferred 1900/0%	86545CT1340013	Off	Gold	1.3611	Century Preferred	All	86545CT1340013	Renewing	33.4%
Gold HMO Pathway X Enhanced, a Multi-State Plan	86545CT1470002	On	Gold	1.0864	Pathway X Enhanced	All	86545CT1470002	Renewing	27.3%
Silver PPO Pathway X, a Multi-State Plan	86545CT1480002	On	Silver	1.0249	Pathway X	All	86545CT1480002	Renewing	21.5%

NOTES:

{1} Plan level increases in rates do not include demographic changes in the population.

Exhibit B - Claims Experience for Rate Developments

Anthem Health Plans, Inc.
Individual

Experience Rate Claims Experience

Incurred January 1, 2015 through December 31, 2015
Paid through March 31, 2016

PAID CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			CSR	Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Receivable	Benefit Expense	Months	PMPM
$225,164,869	$65,366,333	$2,852,551	$35,328	$228,017,420	$65,401,661	$191	(8,341,105)	$285,078,168	629,207	**$453.08**

ALLOWED CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			CSR	Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Receivable	Benefit Expense	Months	PMPM
$277,765,810	$75,091,580	$3,411,982	$39,544	$281,177,792	$75,131,124	$191	N/A	$356,309,106	629,207	**$566.28**

Note

{1} The 'Experience Rate Claims Experience' above does not account for Rx Rebates; whereas, the claims shown in Worksheet 1, Section 1 of the URRT include them.

{2} Drug Claims are processed by an external vendor.

Exhibit C - Market Adjusted Index Rate Development

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

		Experience Rate	
1)	Starting Paid Claims PMPM	$453.08	Exhibit B
2)	x Normalization Factor	0.9752	Exhibit D
3)	= Normalized Claims	$441.84	= (1) x (2)
4)	x Benefit Changes	0.9970	Exhibit E
5)	x Morbidity Changes	0.9697	Exhibit E
6)	x Trend Factor	1.2013	Exhibit E
7)	x Other Cost of Care Impacts	1.0093	Exhibit E
8)	= Projected Paid Claim Cost	**$517.93**	= (3) x (4) x (5) x (6) x (7)
9)	Credibility Weight	100.00%	
10)	Blended Paid Claims	$517.93	
11)	- Non-EHBs Embedded in Line Item 1) Above	$1.01	
12)	= Projected Paid Claims, Excluding ALL Non-EHBs	$516.92	= (10) - (11)
13)	+ Rx Rebates	-$10.51	Exhibit F
14)	+ Additional EHBs	$3.36	Exhibit F
15)	= Projected Paid Claims for EHBs	$509.77	= (12) + (13) + (14)
16)	÷ Paid to Allowed Ratio	0.7593	
17)	**= Index Rate** {2}	**$671.37**	= (15) / (16)
18)	Reinsurance Contribution	$0.00	Exhibit G
19)	Expected Reinsurance Payments	$0.00	Exhibit G
20)	Risk Adjustment Fee	$0.13	Exhibit G
21)	Risk Adjustment Net Transfer	-$31.21	Exhibit G
22)	Exchange User Fee	$9.53	Exhibit H
23)	**= Market Adjusted Index Rate** {3}	$642.99	= (17)+[(18)+(19)+(20)+(21)+(22)] ÷ (16)

NOTE:

{1} Factors above are detailed in subsequent exhibits

{2} Index Rate is Projected Allowed Claims for EHBs only

{3} The Market Adjusted Index Rate is the same for all plans in the single risk pool

Exhibit D - Normalization Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

	Average Claim Factors - Experience Rate		
	Experience Period Population	Future Population	Normalization Factor [1]
Age/Gender	1.0318	1.0316	0.9998
Area	0.9891	0.9816	0.9924
Network	0.9323	0.9335	1.0013
Benefit Plan	0.7066	0.6936	0.9816
Total			**0.9752**

Note

{1} Nomalization Factor = Future Population Factor / Experience Period Population Factor

Exhibit E - Projection Period Adjustments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Impact of Changes Between Experience Period and Projection Period:		
		Experience Rate
Benefit changes		
	EHB Changes	1.0018
	Network Adjustments	0.9952
	Total Benefit Changes	0.9970
Morbidity changes		
	Total Morbidity Changes	0.9697
Trend & Other Cost of Care impacts		
	Annual Medical/Rx Trend Rate	9.6%
	# Months of Projection	24.1
	Trend Factor	1.2013
	Other Cost of Care:	
	Medical Management	1.0011
	Induced Demand for CSR	1.0010
	Grace Period	1.0072
	Total other Cost of Care Impacts	1.0093

Note

{1} Explanation of the factors above is provided in the Actuarial Memorandum

Exhibit F - Other Claim Adjustments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Other Claim Adjustments	
	PMPM
Rx Rebates	($10.51)
Additional EHBs	
Pediatric Dental	$3.08
Pediatric Vision	$0.28
Total - Additional EHBs	$3.36
Additional non-EHBs	
CCP Packages, Adult Dental, Adult Vision	$0.01
Non-EHB pmpm (in experience)	$0.04
Elective Abortion (if Non-EHB)	$0.97
Total - Additional Non-EHBs	$1.02

NOTES:

{1} This exhibit includes projected claims from lines 13 & 14 of Exhibit C and additional non EHBs.

Exhibit G - Risk Adjustment and Reinsurance - Contributions and Payments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Risk Adjustment:		
PMPM	**User Fee** {1}	**Net Transfer** {2}
Federal Program	$0.13	($31.21)

Reinsurance: {3}		
PMPM	**Contributions Made**	**Expected Receipts**
Federal Program	$0.00	$0.00

Grand Total of All Risk Mitigation Programs	($31.08)

NOTES:

{1} For 2017, HHS established a per capita annual user fee rate of $1.56 per year or $0.13 per-enrollee-per-month.

{2} Projected risk adjustment transfer amount is explained in the Memorandum "Risk Adjustment and Reinsurance" Section.

{3} Federal Reinsurance Program is no longer applicable starting in 2017.

Exhibit H - Non-Benefit Expenses and Profit & Risk

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

	Expenses Applied As a PMPM Cost	Expenses Applied as a % of Premium [1]	Expenses Expressed as a PMPM [4]
Administrative Expenses			
Administrative Costs	$32.42		$32.42
Quality Improvement Expense	$6.89		$6.89
Selling Expense		0.53%	$3.08
Specialty Expenses	$0.53		$0.53
Misc Admin (PMPM) [5]	$2.37		$2.37
Total Administrative Expenses	**$42.21**	**0.53%**	**$45.29**
Taxes and Fees			
PCORI Fee	$0.20		$0.20
ACA Insurer Fee		0.00%	$0.00
Exchange User Fee		1.65%	$9.53
Premium Tax		1.75%	$10.11
MLR-Deductible Federal/State Income Taxes [2]		1.75%	$10.11
Misc Taxes & Fees (% prem) [6]		0.66%	$3.81
Total Taxes and Fees	**$0.20**	**5.81%**	**$33.75**
Profit and Risk Margin [3]		3.25%	$18.77
Total Non-Benefit Expenses, Profit, and Risk	**$42.41**	**9.59%**	**$97.81**

NOTES:

{1} The sum of the rounded percentages shown may not equal the total at the bottom of the table due to rounding.

{2} Includes only those income taxes which are deductible from the MLR denominator; in particular, Federal income taxes on investment income are excluded.

{3} Profit and Risk Margin shown here is post-tax profit, net of those federal and state income taxes which are deductible from the MLR denominator.

{4} Anthem's Non-Benefit Expenses are applied in both PMPM and % of Premium as shown above. The last column expresses all non-benefit Expenses in PMPM only.

{5} Includes charge for State of Connecticut Vaccine Immunization Program and the DPH assessment.

{6} Includes charges for DOI Fees and Assessments.

Exhibit I - Federal MLR Estimated Calculation

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Numerator:		
Incurred Claims {1}	$510.79	Exhibit C (Line 15) + Exhibit F (Total Non-EHBs)
+ Quality Improvement Expense	$6.89	Exhibit H
+ Risk Corridor Contributions	$0.00	
+ Risk Adjustment Net Transfer	-$31.21	Exhibit G
+ Reinsurance Receipts	$0.00	Exhibit G
+ Risk Corridor Receipts	$0.00	
+ Reduction to Rx Incurred Claims (ACA MLR)	-$11.45	Footnote {3}
= *Estimated* Federal MLR Numerator	$475.03	
Denominator:		
Premiums {2}	$577.52	Incurred Claims + Exhibit G (Total) + Exhibit H (Total)
- Federal and State Taxes	$10.11	Exhibit H (Federal/State Income Taxes)
- Premium Taxes	$10.11	Exhibit H (Premium Tax)
- Risk Adjustment User Fee	$0.13	Exhibit G
- Reinsurance Contributions	$0.00	Exhibit G
- Misc Admin (PMPM)	$2.37	Exhibit H
- Misc Taxes & Fees (% of Premium)	$3.81	Exhibit H
- Licensing and Regulatory Fees	$9.73	Exhibit H (PCORI, ACA and Exchange Fees)
= *Estimated* Federal MLR Denominator	$541.26	
***Estimated* Federal MLR**	**87.76%**	

NOTES:

{1} Incurred Claims = Projected Paids Claims for EHB (Exhibit C Line 15) + additional non EHBs (Exhibit F Total Non-EHBs)

{2} Premiums = Incurred Claims in this exhibit + Risk Mitigation Programs in Exhibit G + Non-Benefit Expenses and Profit & Risk Margin in Exhibit H

{3} This is the amount of 2017 pharmacy claims that are attributable to PBM Administrative Expenses (i.e. the "retail spread" or "pharmacy claims margin"). It is calculated by applying the 3rd party margin percentage to the 2017 projected Pharmacy claims including projected rebates.

{4} The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

* The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.

* Not all numerator/denominator components are captured above (for example, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).

* Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.

* Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule.

Exhibit J - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit C)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs {2}	Plan Adjusted Index Rate {3}	Calibration Factor {4}	Consumer Adjusted Premium Rate {5}
Catastrophic HMO Pathway X Enhanced	86545CT1230005	$642.99	0.5447	0.9516	1.0034	0.8169	$47.66	$320.87	1.6332	$196.47
Bronze HMO Pathway X Enhanced	86545CT1230002	$642.99	0.6122	0.9516	1.0025	1.0000	$65.29	$440.83	1.6332	$269.92
Bronze HMO Pathway X Enhanced for HSA	86545CT1230001	$642.99	0.6028	0.9516	1.0025	1.0000	$64.30	$434.06	1.6332	$265.77
Gold HMO Pathway X Enhanced	86545CT1230004	$642.99	0.8589	0.9516	1.0018	1.0000	$91.30	$617.79	1.6332	$378.27
Anthem HMO Catastrophic BlueCare 7150/0%	86545CT1310033	$642.99	0.5447	1.0761	1.0034	0.8169	$59.79	$368.74	1.6332	$225.78
Anthem Bronze HMO BlueCare 6200/12400/0% for HSA	86545CT1310019	$642.99	0.6069	1.0761	1.0025	1.0000	$81.25	$502.25	1.6332	$307.52
Anthem Silver HMO BlueCare 3850/0%	86545CT1310031	$642.99	0.6667	1.0761	1.0023	1.0000	$89.18	$551.56	1.6332	$337.72
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	86545CT1310030	$642.99	0.6969	1.0761	1.0022	1.0000	$93.19	$576.43	1.6332	$352.95
Anthem Silver HMO BlueCare Tiered 3550/6400/0%	86545CT1310042	$642.99	0.6484	1.0761	1.0024	1.0000	$86.76	$536.47	1.6332	$328.48
Anthem Gold HMO BlueCare 1500/0%	86545CT1310032	$642.99	0.8581	1.0761	1.0018	1.0000	$114.56	$709.39	1.6332	$434.36
Anthem Gold HMO BlueCare Tiered 1650/3300/0%	86545CT1310041	$642.99	0.9016	1.0761	1.0017	1.0000	$120.32	$745.24	1.6332	$456.31
Bronze PPO Standard Pathway X	86545CT1330002	$642.99	0.5965	0.9611	1.0026	1.0000	$64.26	$433.82	1.6332	$265.63
Bronze PPO Standard Pathway X for HSA	86545CT1330009	$642.99	0.6078	0.9611	1.0025	1.0000	$65.48	$442.06	1.6332	$270.67
Silver PPO Pathway X	86545CT1330004	$642.99	0.8150	0.9611	1.0019	1.0000	$87.54	$592.19	1.6332	$362.59
Silver PPO Standard Pathway X	86545CT1330001	$642.99	0.8135	0.9611	1.0019	1.0000	$87.37	$591.05	1.6332	$361.90
Silver Core PPO Pathway X 5300	86545CT1330010	$642.99	0.8108	0.9611	1.0038	1.0000	$88.26	$591.27	1.6332	$362.03
Gold PPO Standard Pathway X	86545CT1330003	$642.99	1.0880	0.9611	1.0014	1.0000	$116.61	$789.98	1.6332	$483.70
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	86545CT1340005	$642.99	0.5629	1.0869	1.0027	1.0000	$76.16	$470.60	1.6332	$288.15
Anthem Bronze PPO Century Preferred 7150/0%	86545CT1340010	$642.99	0.5339	1.0869	1.0029	1.0000	$72.29	$446.49	1.6332	$273.39
Anthem Silver PPO Century Preferred 2750	86545CT1340006	$642.99	0.6807	1.0869	1.0023	1.0000	$91.94	$568.70	1.6332	$348.21
Anthem Silver PPO Century Preferred 3000/6000 for HSA	86545CT1340011	$642.99	0.6673	1.0869	1.0023	1.0000	$90.15	$557.58	1.6332	$341.40
Anthem Gold PPO Century Preferred 1500/4500 for HSA	86545CT1340012	$642.99	0.8181	1.0869	1.0019	1.0000	$110.35	$683.17	1.6332	$418.30
Anthem Gold PPO Century Preferred 1900/0%	86545CT1340013	$642.99	0.9417	1.0869	1.0017	1.0000	$126.89	$786.06	1.6332	$481.30
Gold HMO Pathway X Enhanced, a Multi-State Plan	86545CT1470002	$642.99	0.8738	0.9516	1.0001	1.0000	$92.72	$627.44	1.6332	$384.18
Silver PPO Pathway X, a Multi-State Plan	86545CT1480002	$642.99	0.8162	0.9611	1.0001	1.0000	$87.50	$591.93	1.6332	$362.43

Notes:

{1} This adjustment reflects the projected costs of the population eligible for catastrophic plans.

{2} This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H, with the exception of the Exchange user fee. The Exchange user fee has been included in the Market Adjusted Index Rate at the market level.

{3} The Plan Adjusted Index Rate is calculated by multiplying the Market Adjusted Index Rate by the AV and cost sharing, provider network, benefits in addition to the EHBs, and catastrophic plan adjustments and then adding the administrative costs. The Plan Adjusted Index Rate can also be described as a Plan Level Required Premium.

{4} See Exhibit K - Calibration.

{5} The Consumer Adjusted Premium Rate is equal to 'Plan Adjusted Index Rate' divided by 'Calibration Factor'

Exhibit K - Calibration

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Average rating factors for 2017 population:	
	Calibration Factors
Age	1.6638
Area	0.9816
Total Calibration Factor{1}	1.6332

NOTES:

{1} Total Calibration factor was used in Exhibit J.

Exhibit L - Age and Tobacco Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

	Age Factors	Tobacco Factors
Age	**2017**	**2017**
0-17	0.635	1.000
18	0.635	1.000
19	0.635	1.000
20	0.635	1.000
21	1.000	1.000
22	1.000	1.000
23	1.000	1.000
24	1.000	1.000
25	1.004	1.000
26	1.024	1.000
27	1.048	1.000
28	1.087	1.000
29	1.119	1.000
30	1.135	1.000
31	1.159	1.000
32	1.183	1.000
33	1.198	1.000
34	1.214	1.000
35	1.222	1.000
36	1.230	1.000
37	1.238	1.000
38	1.246	1.000
39	1.262	1.000
40	1.278	1.000
41	1.302	1.000
42	1.325	1.000
43	1.357	1.000
44	1.397	1.000
45	1.444	1.000
46	1.500	1.000
47	1.563	1.000
48	1.635	1.000
49	1.706	1.000
50	1.786	1.000
51	1.865	1.000
52	1.952	1.000
53	2.040	1.000
54	2.135	1.000
55	2.230	1.000
56	2.333	1.000
57	2.437	1.000
58	2.548	1.000
59	2.603	1.000
60	2.714	1.000
61	2.810	1.000
62	2.873	1.000
63	2.952	1.000
64+	3.000	1.000

NOTES:
The weighted average of these factors for the entire risk pool included in this rate filing is provided in Exhibit K.

Exhibit M - Area Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Rating Area Description	2017 Area Rating Factor	2016 Area Rating Factor	Change
Fairfield	1.1200	1.1000	1.8%
Hartford	0.9200	0.8700	5.7%
Litchfield	0.9200	0.8700	5.7%
Middlesex	1.0100	0.9500	6.3%
New Haven	0.9500	0.9500	0.0%
New London	0.9200	0.8700	5.7%
Tolland	0.9200	0.8700	5.7%
Windham	0.9200	0.8700	5.7%
Out of Area	1.0000	1.0000	0.0%

NOTES:

{1} The weighted average of these factors for the entire risk pool included in this rate filing is provided in Exhibit K.

Exhibit N - Sample Rate Calculation

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Name: **John Doe**
Effective Date: **1/1/2017**
On/Off Exchange: Off
Metal Level: Bronze
Plan ID: 86545CT1310019
Rating Area: 01

Family Members Covered:

	Age
Subscriber	47
Spouse	42
Child (age 21+)	25
Child #1	20
Child #2	16

Calculation of Monthly Premium:

Consumer Adjusted Premium Rate	$307.52	Exhibit J
x Area Factor	1.1200	Exhibit M
Rate Adjusted for Area =	$344.43	

Age Factors: Exhibit L

	Age Factor
Subscriber	1.563
Spouse	1.325
Child (age 21+)	1.004
Child #1	0.635
Child #2	0.635

Final Monthly Premium PMPM:

	PMPM
Subscriber	$538.34
Spouse	$456.37
Child (age 21+)	$345.81
Child #1	$218.71
Child #2	$218.71
TOTAL	**$1,777.94**

NOTES:

As per the Market Reform Rule, when computing family premiums no more than the three oldest covered children under the age of 21 are taken into account whereas the premiums associated with each child age 21+ are included.

Minor rate variances may occur due to differences in rounding methodology.

Exhibit O - Membership Projections for Cost-Sharing Reductions

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Silver Plan	Projected Membership by Subsidy Level:			
HIOS Standard Component Plan ID	100-150%	150%-200%	200%-250%	Standard
86545CT1310031	0	0	0	1,470
86545CT1310030	0	0	0	2,100
86545CT1310042	0	0	0	1,050
86545CT1330004	444	508	321	1,352
86545CT1330001	2,844	3,250	2,055	8,651
86545CT1330010	89	102	64	270
86545CT1340006	0	0	0	2,310
86545CT1340011	0	0	0	630
86545CT1480002	195	223	141	596

Exhibit P - Terminated Plans

Anthem Health Plans, Inc.
Individual

Effective January 1, 2017

Following are the plans that will be terminated prior to the effective date:

This includes plans that have experience included in the URRT during the experience period and any plans that were not in effect during the experience period but were made available thereafter.

Post ACA Terminated Plans

Plan ID	Plan Name	HIOS Product ID	HIOS Product Name	2017 Mapped HIOS Plan ID
86545CT1310018	Anthem HMO BlueCare 0% for HSA	86545CT131	HMO - Off Exchange	86545CT1310019
86545CT1310020	Anthem HMO BlueCare 5500/0%	86545CT131	HMO - Off Exchange	86545CT1310019
86545CT1310024	Anthem HMO BlueCare 6000/0%	86545CT131	HMO - Off Exchange	86545CT1310019
86545CT1310035	Anthem Gold HMO Pathway X Enhanced 1850/0%	86545CT131	HMO - Off Exchange	NA
86545CT1310039	Anthem Bronze HMO BlueCare 6550/13100/0% for HSA	86545CT131	HMO - Off Exchange	86545CT1310019
86545CT1310040	Anthem Silver HMO BlueCare Tiered 3000/3850/0%	86545CT131	HMO - Off Exchange	NA
86545CT1310043	Anthem Gold HMO BlueCare Tiered 2000/3500/0%	86545CT131	HMO - Off Exchange	NA
86545CT1340007	Anthem PPO Century Preferred 2500/20%	86545CT134	PPO - Off Exchange	86545CT1340006
86545CT1340008	Anthem HMO BlueCare 3500/0%	86545CT134	HMO - Off Exchange	86545CT1310031
86545CT1340014	Anthem Silver PPO Century Preferred 3500/7000/10%	86545CT134	PPO - Off Exchange	86545CT1310042
86545CT1340015	Anthem Silver PPO Century Preferred Tiered 2850/4000/0%	86545CT134	PPO - Off Exchange	NA
86545CT1340016	Anthem Gold PPO Century Preferred Tiered 1750/3250/0%	86545CT134	PPO - Off Exchange	NA

{1} Plans that were offered in 2015 or 2016 that have 0 members were not mapped to a 2017 plan. These plans are indicated "NA" in the "2017 Mapped HIOS Plan ID" Column.

Exhibit Q - Trend

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Rating Trend

Based on the considerations below, Anthem proposes a 9.6% rating trend. The rating trend is developed from the expected paid trend. Individual 2014 and 2015 trends are volatile and high as the ACA experience develops. The rating trend projection is based on Small Group trend projections with additional adjustments to account for Individual's higher Hepatitis C utilization and higher trend experience through April 2016.

Observed Paid Trends

Observed trends have been normalized to remove the impact of aging and morbidity, shifts in gender, mandates, and impact of medical benefit changes.

Benefit Buy Downs

Cost and utilization data in the experience periods includes the impact of benefit buy-downs. The trend process is normalized for benefit buy-down to develop a projected trend for 2016 and 2017.

Provider Contracting

Provider contracting is included in the Unit Cost Data.

Leveraging

The use of Paid Claims removes the need to adjust for Leveraging.

Other Trend Components

Medical technology trend is included in observed experience and is not an independent assumption.

Historical Cost and Utilization Paid Data		Inpatient	Outpatient	Professional	Rx Drug	Total
Normalized Unit Cost Data (Paid)						
	CY 2012	$3,869.21	$787.74	$124.24	$49.00	
	CY 2013	$3,899.81	$853.68	$128.71	$53.64	
	CY 2014	$3,638.84	$772.01	$122.76	$74.74	
	CY 2015	$3,854.59	$811.14	$131.56	$106.31	
	CY 2016	$3,764.16	$754.71	$129.19	$124.66	
	CY 2017	$3,862.60	$754.03	$128.82	$140.20	
Utilization Data (per thousand members)						
	CY 2012	16.1	116.6	803.5	697.0	1,633.3
	CY 2013	14.2	120.7	814.7	717.6	1,667.2
	CY 2014	27.7	161.1	849.4	884.3	1,922.5
	CY 2015	30.3	179.3	908.4	1,084.4	2,202.4
	CY 2016	32.6	206.2	959.3	1,219.9	2,418.0
	CY 2017	34.2	228.9	998.6	1,232.1	2,493.8
Paid PMPM						
	CY 2012	$62.23	$91.88	$99.83	$34.15	$288.10
	CY 2013	$55.31	$103.04	$104.86	$38.49	$301.70
	CY 2014	$100.76	$124.38	$104.27	$66.09	$395.50
	CY 2015	$116.91	$145.44	$119.51	$115.27	$497.14
	CY 2016	$122.73	$155.62	$123.93	$152.07	$554.36
	CY 2017	$132.24	$172.58	$128.64	$172.74	$606.21
Paid Trend						
	2013/2012	-11.1%	12.1%	5.0%	12.7%	4.7%
	2014/2013	82.2%	20.7%	-0.6%	71.7%	31.1%
	2015/2014	16.0%	16.9%	14.6%	74.4%	25.7%
	2016/2015	5.0%	7.0%	3.7%	31.9%	11.5%
	2017/2016	7.7%	10.9%	3.8%	13.6%	9.4%
2 Year Trends						
	2014/2012	27.2%	16.3%	2.2%	39.1%	17.2%
	2015/2013	45.4%	18.8%	6.8%	73.0%	28.4%
	2016/2014	10.4%	11.9%	9.0%	51.7%	18.4%
	2017/2015	6.4%	8.9%	3.7%	22.4%	10.4%

Exhibit R - Claims Lag Triangle

Anthem Health Plans, Inc.
Individual

Paid through March 31, 2016

	Lag																								
Incurred Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25+
201401	$1	$628,394	$1,042,531	$1,175,819	$1,700,300	$968,726	$1,353,383	$604,857	$552,791	$730,143	$378,153	$363,477	$46,063	$23,814	-$22,664	$73,100	$92,171	-$18,375	$127,490	-$39,084	$10,362	-$1,692	$44,973	-$4,552	$821
201402	$990,807	$1,992,592	$1,833,288	$1,502,209	$1,751,968	$1,332,736	$832,943	$424,330	$674,126	$371,921	$168,133	$107,249	$31,574	$28,301	$81,036	$86,232	-$17,747	$8,226	$1,767	-$22,217	$1,804	$88,390	-$28,598	$1,930	$14,090
201403	$3,073,987	$3,728,381	$2,604,656	$2,323,999	$980,755	$320,040	$467,590	$853,664	$310,822	$498,574	$191,056	$63,338	$119,468	$104,375	-$19,901	-$32,329	-$38,391	$23,538	$33,151	-$63,599	$73,015	$12,247	-$11,242	-$2,635	$3,579
201404	$3,586,662	$7,010,498	$3,043,837	$1,099,143	$779,526	$384,850	$1,099,288	$481,146	$325,841	$97,575	$66,679	$27,607	$82,718	-$17,530	$98,567	$28,488	$66,348	-$90,939	$17,303	$30,737	$20,333	-$6,800	$4,811	$54,728	$0
201405	$6,316,019	$8,810,455	$1,997,673	$701,163	$552,415	$835,450	$760,301	$289,601	$148,499	$115,487	-$221,110	$12,452	$41,170	-$6,007	$343,344	-$29,737	$4,112	$7,274	$11,179	$14,162	-$30,793	-$16,471	$3,309	$0	$0
201406	$7,737,072	$8,091,548	$1,991,709	$1,122,809	$787,048	$746,408	$356,238	$239,441	$119,004	$8,290	$229,907	$352	-$25,596	$97,573	$10,264	-$83,421	$8,435	$17,845	-$18,794	$5,102	$2,020	-$25,904	$0	$0	$0
201407	$7,145,365	$9,833,781	$2,413,022	$1,235,353	$584,923	$451,784	$136,235	-$5,443	-$85,323	$171,850	$53,346	$44,368	-$6,942	-$25,424	$219	$73,176	-$13,299	$24,951	-$9,870	$32,945	$27,415	$0	$0	$0	$0
201408	$8,221,911	$10,021,892	$2,693,921	$522,532	$353,427	$150,129	$136,933	-$38,697	$121,188	$122,686	-$62,377	$26,590	-$5,283	-$91,275	$43,064	$69,463	$30,116	-$268	$544	$3,028	$0	$0	$0	$0	$0
201409	$7,760,660	$12,076,202	$1,164,931	$449,756	$446,087	$151,575	-$44,224	$154,644	-$23,393	-$35,689	$29,130	$29,925	-$22,468	$9,286	$13,841	$16,783	-$19,563	$3,184	-$160	$0	$0	$0	$0	$0	$0
201410	$9,301,779	$11,500,662	$3,236,327	$545,846	$122,331	$165,037	$221,631	$70,554	$3,643	$46,030	$74,014	-$6,111	$47,802	$23,348	-$27,106	$14,897	$702,878	-$10,556	$0	$0	$0	$0	$0	$0	$0
201411	$8,091,452	$12,844,359	$1,426,766	$522,528	$350,816	$335,366	$198,010	$66,212	-$25,940	-$1,390	$416,514	$108,110	$15,901	$66,577	$3,372	$6,578	-$20,335	$0	$0	$0	$0	$0	$0	$0	$0
201412	$12,231,375	$10,633,258	$1,312,618	$683,414	$478,451	$514,818	$64,416	$65,561	$551,185	$682,160	$41,739	-$40,468	-$31,421	$38,337	$11,690	-$62,984	$0	$0	$0	$0	$0	$0	$0	$0	$0
201501	$6,878,596	$7,668,661	$1,922,620	$658,971	$682,634	$401,001	$176,315	$29,320	$43,876	$166,852	-$60,127	$66,030	$43,948	$42,226	$167,635	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201502	$8,009,927	$8,969,242	$1,951,611	$494,306	$469,832	$119,712	$137,350	$63,903	$160,589	$74,936	$2,856	$33,486	$48,351	$167,844	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201503	$9,885,836	$11,298,416	$1,922,939	$575,734	$541,188	$153,589	-$45,090	$136,191	$114,690	$103,680	$11,672	$24,917	$27,155	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201504	$8,957,736	$11,712,500	$1,690,365	$622,970	$254,055	$268,307	$221,094	$243,145	-$29,676	$110,913	$251,616	-$4,536	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201505	$9,188,185	$10,574,435	$2,096,465	$352,922	$391,143	$284,792	$51,087	$36,345	$39,922	$37,663	$98,240	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201506	$10,656,939	$11,378,410	$1,121,477	$1,814,657	$379,046	$280,766	$101,301	$164,219	$123,922	$39,524	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201507	$12,286,297	$9,560,250	$2,424,264	$764,947	$251,535	$165,942	$123,391	$55,676	$133,854	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201508	$9,645,360	$10,433,901	$2,183,262	$681,642	$572,723	$79,808	$69,857	$156,130	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201509	$8,722,048	$11,671,780	$2,227,757	$673,206	$235,483	$81,816	$90,375	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201510	$10,830,421	$11,667,014	$2,458,568	$946,315	$187,407	$227,276	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201511	$8,985,736	$13,002,610	$1,650,480	$273,335	$726,566	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201512	$11,371,421	$12,498,798	$1,483,468	$1,167,233	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Notes:

{1} As noted in Section 28. State Actuarial Memorandum Requirements, this exhibit displays the claim lag triangle for Individual ACA experience, which was the basis of the Individual ACA rate development.

Exhibit S - Historical Experience

Anthem Health Plans, Inc.

Individual

	CT Individual						CT Individual Non-ACA						CT Individual ACA					
	Member Months	Premium PMPM	Incurred Benefit Expense PMPM	Paid Benefit Expense PMPM	Incurred Loss Ratio	Paid Loss Ratio	Member Months	Premium PMPM	Incurred Benefit Expense PMPM	Paid Benefit Expense PMPM	Incurred Loss Ratio	Paid Loss Ratio	Member Months	Premium PMPM	Incurred Benefit Expense PMPM	Paid Benefit Expense PMPM	Incurred Loss Ratio	Paid Loss Ratio
CY 2011	**638,974**	**$311.05**	**$263.05**	**$255.73**	**84.6%**	**82.2%**	**638,974**	**$311.05**	**$263.05**	**$255.73**	**84.6%**	**82.2%**	-	**$0.00**	**$0.00**	**$0.00**	**0.0%**	**0.0%**
CY 2012	**611,781**	**$313.13**	**$285.93**	**$287.60**	**91.3%**	**91.8%**	**611,781**	**$313.13**	**$285.93**	**$287.60**	**91.3%**	**91.8%**	-	**$0.00**	**$0.00**	**$0.00**	**0.0%**	**0.0%**
CY 2013	**559,741**	**$339.84**	**$302.92**	**$307.77**	**89.1%**	**90.6%**	**559,741**	**$339.84**	**$302.92**	**$307.77**	**89.1%**	**90.6%**	-	**$0.00**	**$0.00**	**$0.00**	**0.0%**	**0.0%**
201401	46,946	$419.77	$202.09	$141.69	48.1%	33.8%	15,509	$257.55	$136.62	$588.29	53.0%	228.4%	31,437	$499.80	$234.39	-$78.62	46.9%	-15.7%
201402	49,367	$439.49	$220.41	$35.27	50.2%	8.0%	14,595	$262.40	$106.32	$209.59	40.5%	79.9%	34,772	$513.82	$268.30	-$37.90	52.2%	-7.4%
201403	51,738	$443.26	$278.60	$95.18	62.9%	21.5%	14,107	$254.30	$192.07	$194.42	75.5%	76.5%	37,631	$514.09	$311.04	$57.97	60.5%	11.3%
201404	55,564	$447.18	$282.78	$141.77	63.2%	31.7%	13,612	$260.17	$151.19	$162.14	58.1%	62.3%	41,952	$507.85	$325.48	$135.16	64.1%	26.6%
201405	61,308	$439.30	$282.80	$260.24	64.4%	59.2%	13,262	$259.94	$176.51	$188.74	67.9%	72.6%	48,046	$488.81	$312.14	$279.98	63.9%	57.3%
201406	61,125	$448.20	$290.65	$345.77	64.8%	77.1%	13,067	$289.19	$156.89	$170.44	54.3%	58.9%	48,058	$491.44	$327.02	$393.45	66.5%	80.1%
201407	60,720	$445.57	$309.37	$300.92	69.4%	67.5%	12,822	$264.78	$195.41	$164.19	73.8%	62.0%	47,898	$493.96	$339.88	$337.52	68.8%	68.3%
201408	60,475	$442.80	$304.68	$319.56	68.8%	72.2%	12,600	$264.63	$175.51	$173.14	66.3%	65.4%	47,875	$489.69	$338.67	$358.10	69.2%	73.1%
201409	60,235	$439.61	$310.52	$338.40	70.6%	77.0%	12,310	$265.25	$177.57	$192.32	66.9%	72.5%	47,925	$484.40	$344.67	$375.92	71.2%	77.6%
201410	59,867	$438.05	$376.30	$443.15	85.9%	101.2%	11,993	$266.76	$231.03	$216.60	86.6%	81.2%	47,874	$480.96	$412.69	$499.90	85.8%	103.9%
201411	59,247	$431.87	$360.47	$372.32	83.5%	86.2%	11,830	$261.67	$194.29	$218.55	74.2%	83.5%	47,417	$474.33	$401.93	$410.69	84.7%	86.6%
201412	57,387	$426.45	$440.10	$503.75	103.2%	118.1%	11,468	$257.20	$277.24	$228.00	107.8%	88.6%	45,919	$468.71	$480.77	$572.61	102.6%	122.2%
CY 2014	**683,981**	**$438.77**	**$307.98**	**$283.29**	**70.2%**	**64.6%**	**157,175**	**$263.52**	**$178.02**	**$231.05**	**67.6%**	**87.7%**	**526,806**	**$491.06**	**$346.76**	**$298.87**	**70.6%**	**60.9%**
201501	51,844	$479.86	$311.13	$352.08	64.8%	73.4%	-	$0.00	$0.00	$0.00	0.0%	0.0%	51,844	$479.86	$311.13	$352.08	64.8%	73.4%
201502	53,269	$483.36	$323.15	$278.08	66.9%	57.5%	-	$0.00	$0.00	$0.00	0.0%	0.0%	53,269	$483.36	$323.15	$278.08	66.9%	57.5%
201503	56,281	$477.16	$365.45	$311.09	76.6%	65.2%	-	$0.00	$0.00	$0.00	0.0%	0.0%	56,281	$477.16	$365.45	$311.09	76.6%	65.2%
201504	54,738	$479.80	$373.24	$383.77	77.8%	80.0%	-	$0.00	$0.00	$0.00	0.0%	0.0%	54,738	$479.80	$373.24	$383.77	77.8%	80.0%
201505	54,177	$482.48	$360.74	$395.87	74.8%	82.0%	-	$0.00	$0.00	$0.00	0.0%	0.0%	54,177	$482.48	$360.74	$395.87	74.8%	82.0%
201506	53,302	$478.34	$427.21	$395.37	89.3%	82.7%	-	$0.00	$0.00	$0.00	0.0%	0.0%	53,302	$478.34	$427.21	$395.37	89.3%	82.7%
201507	52,645	$474.83	$421.51	$457.74	88.8%	96.4%	-	$0.00	$0.00	$0.00	0.0%	0.0%	52,645	$474.83	$421.51	$457.74	88.8%	96.4%
201508	52,154	$474.53	$388.22	$349.56	81.8%	73.7%	-	$0.00	$0.00	$0.00	0.0%	0.0%	52,154	$474.53	$388.22	$349.56	81.8%	73.7%
201509	51,547	$471.87	$393.56	$413.90	83.4%	87.7%	-	$0.00	$0.00	$0.00	0.0%	0.0%	51,547	$471.87	$393.56	$413.90	83.4%	87.7%
201510	50,649	$469.70	$461.11	$463.02	98.2%	98.6%	-	$0.00	$0.00	$0.00	0.0%	0.0%	50,649	$469.70	$461.11	$463.02	98.2%	98.6%
201511	49,822	$464.72	$423.35	$417.58	91.1%	89.9%	-	$0.00	$0.00	$0.00	0.0%	0.0%	49,822	$464.72	$423.35	$417.58	91.1%	89.9%
201512	48,778	$457.30	$484.79	$510.13	106.0%	111.6%	-	$0.00	$0.00	$0.00	0.0%	0.0%	48,778	$457.30	$484.79	$510.13	106.0%	111.6%
CY 2015	**629,207**	**$474.72**	**$393.32**	**$392.41**	**82.9%**	**82.7%**	**-**	**$0.00**	**$0.00**	**$0.00**	**0.0%**	**0.0%**	**629,207**	**$474.72**	**$393.32**	**$392.41**	**82.9%**	**82.7%**

Notes:

[1] Premium includes expected risk adjustment.

{2} Incurred and Paid benefit expenses include capitation, drug rebates, medical management fees, claims expense reclasses, CSR subsidies, Reinsurance recoveries, and other non-core claim accounts.

{3} As noted in Section 4. Experience Period Premium and Claims, this exhibit details historical experience for the policy forms included in this filing.

Exhibit T - Wigs Certification

Anthem Health Plans – Connecticut

Actuarial Certification

I, Tu Nguyen, am a Director & Actuary III for Anthem Health Plans. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. I certify that the following statements are true to the best of my knowledge:

A search of literature in 2016 shows that synthetic wigs are priced between $30 and $500 while wigs made from real hair run between $800 and $3,000. Based on that review the substitution of 1 wig per year to replace the annual dollar maximum of $350 indicates that the 1 wig per year is a reasonable substitution for a $350 dollar annual limit.

Tu Nguyen, FSA, MAAA
Director & Actuary III
June 1, 2016

Exhibit U - Mental Health Parity Certification

Anthem Health Plans – Connecticut

Actuarial Certification

I, Tu Nguyen, am a Director & Actuary III for Anthem Health Plans. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. I certify that the following statements are true to the best of my knowledge:

Mental Health Parity testing results for each benefit plan are done based upon commonly accepted actuarial assumptions and sound actuarial principles which are consistent with Connecticut Insurance Laws. I certify that each plan meets the "substantially all" and the "predominant" tests set forth in the MHPAEA final rules effective 7/1/14.

Tu Nguyen, FSA, MAAA
Director & Actuary III
June 1, 2016

Appendix A

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

• The requested rate changes for each product can be found in Exhibit A - Non-Grandfathered Rate Changes.

• The number of covered individuals and policyholders for each plan are shown in the table below.

HIOS Plan Name	2017 HIOS Plan ID	On/Off Exchange	Metal Level	February 2016 Covered Members	February 2016 Covered Policyholders	2016 HIOS Plan ID Mapping
Catastrophic HMO Pathway X Enhanced	86545CT1230005	On	Catastrophic	731	718	86545CT1230005
Bronze HMO Pathway X Enhanced	86545CT1230002	On	Bronze	742	494	86545CT1230002
Bronze HMO Pathway X Enhanced for HSA	86545CT1230001	On	Bronze	2,172	1,586	86545CT1230001
Gold HMO Pathway X Enhanced	86545CT1230004	On	Gold	975	625	86545CT1230004
Anthem HMO Catastrophic BlueCare 7150/0%	86545CT1310033	Off	Catastrophic	552	535	86545CT1310033
Anthem Bronze HMO BlueCare 6200/12400/0% for HSA	86545CT1310019	Off	Bronze	1,327	814	86545CT1310019
Anthem Silver HMO BlueCare 3850/0%	86545CT1310031	Off	Silver	1,366	853	86545CT1310031
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	86545CT1310030	Off	Silver	2,122	1,218	86545CT1310030
Anthem Gold HMO BlueCare 1500/0%	86545CT1310032	Off	Gold	3,725	2,215	86545CT1310032
Bronze PPO Standard Pathway X	86545CT1330002	On	Bronze	2,032	1,388	86545CT1330002
Bronze PPO Standard Pathway X for HSA	86545CT1330009	On	Bronze	2,054	1,329	86545CT1330009
Silver PPO Pathway X	86545CT1330004	On	Silver	2,252	1,693	86545CT1330004
Silver PPO Standard Pathway X	86545CT1330001	On	Silver	15,809	11,417	86545CT1330001
Gold PPO Standard Pathway X	86545CT1330003	On	Gold	4,594	2,783	86545CT1330003
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	86545CT1340005	Off	Bronze	4,466	2,313	86545CT1340005
Anthem Bronze PPO Century Preferred 7150/0%	86545CT1340010	Off	Bronze	1,755	1,028	86545CT1340010
Anthem Silver PPO Century Preferred 2750	86545CT1340006	Off	Silver	1,358	757	86545CT1340006
Anthem Silver PPO Century Preferred 3000/6000 for HSA	86545CT1340011	Off	Silver	434	187	86545CT1340011
Anthem Gold PPO Century Preferred 1500/4500 for HSA	86545CT1340012	Off	Gold	431	243	86545CT1340012
Anthem Gold PPO Century Preferred 1900/0%	86545CT1340013	Off	Gold	1,045	547	86545CT1340013
Gold HMO Pathway X Enhanced, a Multi-State Plan	86545CT1470002	On	Gold	507	313	86545CT1470002
Silver PPO Pathway X, a Multi-State Plan	86545CT1480002	On	Silver	1,074	778	86545CT1480002

• Information on current and proposed premium PMPM minimums and maximums can be found in the Rate Review Detail section of the CT Individual filing on SERFF.

• The components of the requested rate change can be found in Exhibit C - Market Adjusted Index Rate Development.

NOTES:
Other factors that impact premium rates include age bands and geographic area.

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Anthem Health Plans, Inc.
State:	Connecticut
HIOS Issuer ID:	86545
NAIC Company Code:	60217
Market:	Individual
Effective Date:	January 1, 2017

- Company Contact Information

Primary Contact Name:	Tu Nguyen
Primary Contact Telephone Number:	(203) 677-8510
Primary Contact Email Address:	Tu.Nguyen@anthem.com

2. Scope and Purpose of the Filing

This is a rate filing for the Individual market ACA-compliant plans offered by Anthem Health Plans, Inc., also referred to as Anthem. The policy forms associated with these plans are listed below. The proposed rates in this filing will be effective for the 2017 plan year beginning January 1, 2017, and apply to plans both On-Exchange and Off-Exchange.

The Memorandum provides support to the rate development and demonstrates that rates are established in compliance with state laws and provisions of the Affordable Care Act. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):

CT ON HIX HMO (1/17)
CT OFF HIX HMO (1/17)
CT ON HIX PPO (1/17)
CT OFF HIX PPO (1/17)

3. Proposed Rate Increase(s)

The proposed annual rate changes by product in this filing range from 21.5% to 32.4%, with rate changes by plan from 16.5% to 39.8%. These ranges are based on the renewing plans, and are consistent with what's reported in the Unified Rate Review Template. Exhibit A shows the rate change for each plan.

Factors that affect the rate changes for all plans include:

- Emerging experience different than projected.
- Trend: This includes the impact of inflation, provider contracting changes, and increased utilization of services.
- Morbidity: There are anticipated changes in the market-wide morbidity of the covered population in the projection period.
- Benefit modifications, including changes made to comply with updated AV requirements.
- Changes in taxes, fees, and some non-benefit expenses, including the one-year suspension of the Health Insurer Tax for 2017.
- Discontinuance of the Federal Transitional Reinsurance Program, which impacts both payments from and contributions to the program.

Although rates are based on the same claims experience, the rate changes vary by plan due to the following factors:

- Changes in benefit design that vary by plan.
- Updates in benefit relativity factors among plans.
- Updated adjustment factors for catastrophic plans.
- Changes in some non-benefit expenses.
- Changes in the claim cost relativity by area.

4. Experience Period Premium and Claims

The experience period premium and claims reported in Worksheet 1, Section I of the Unified Rate Review Template (URRT) are for the non-grandfathered, single risk pool compliant policies of the identified legal entity in the Individual market.

• Paid Through Date

The experience reported in Worksheet 1, Section I of the URRT reflect the incurred claims from January 1, 2015 through December 31, 2015 based on claims paid through March 31, 2016.

- Premiums (net of MLR Rebate) in Experience Period

The earned premium prior to MLR rebate is $298,699,430. The earned premium reflects the pro-rata share of premium based on policy coverage dates, and includes expected risk adjustments for the experience period.

The preliminary MLR rebate estimate is $0, which is consistent with Anthem's December 31, 2015 general ledger estimate allocated to the non-grandfathered portion of Individual business. This is an estimated amount and will not be final until 7/31/2016. Using this MLR estimate, the net earned premium is $298,699,430 for the legal entity as reported in cell F14 of Worksheet 1, Section I of the URRT.

- Allowed and Incurred Claims Incurred During the Experience Period

The allowed claims are determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

Allowed and incurred claims are completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of cumulative claims paid of the ultimate incurred amounts for each lag month. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

Allowed and incurred claims reported in Worksheet 1, Section I of the URRT are $351,107,881 and $279,876,943, respectively. Exhibit B provides claims detail.

5. Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the URRT is as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.

- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, and dental services.
- Capitation: Includes all services provided under one or more capitated arrangements.
- Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

6. Projection Factors

The experience period claims in Worksheet 1, Section I of the URRT are projected to the projection period using the factors described below. Exhibit C provides a summary of the factors.

• Changes in the Morbidity of the Population Insured

Adjustments are made to account for the differences between the average morbidity of the experience period population and that of the anticipated population in the projection period.

The projected population consists of expected retention of existing policies and new sales. The new sales include the previously uninsured population and previously insured populations from other carriers or coverage. The morbidity impacts of population movement are based on the experience period risk score data and estimated risk scores of the projected population. Exhibit E shows the morbidity factor.

• Changes in Benefits

Changes in benefits include the following items. Exhibit E shows each adjustment factor.

- Essential Health Benefit (EHB) Changes: Adjustments are made to reflect the 2017 requirement to provide separate but equal visit limits for rehabilitative and habilitative therapies per HHS Notice of Benefit and Payment Parameters.

- Changes in Demographics (Normalization)

The experience period claims are normalized to reflect anticipated changes in age/gender, area, network, and benefit plan in the projection period. Exhibit D provides detail of each normalization factor below:

- Age/Gender: The assumed claims cost is applied by age and gender to the experience period membership distribution and the projection period membership distribution.
- Area/Network: The area claims factors are developed based on an analysis of allowed claims by network, mapped to the prescribed rating areas using the subscriber's 5-digit zip code.
- Benefit Plan: The experience period claims are normalized to reflect the average benefit level in the projection period using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

- Other Adjustments

Other adjustments to the experience claims data include the following items. Exhibit E and Exhibit F show the factors used for each adjustment.

- Change in Medical Management: This adjustment reflects the medical management costs not already included in the claims experience and trend.
- Induced Demand Due to Cost Share Reductions: Individuals who fall below 250% of the Federal Poverty Level and enroll in On-Exchange silver plans will be eligible for cost share reductions. The percentage of enrollment in CSR Plans in the experience period is compared to that of the projection period to adjust for the different induced demand level due to CSR between the two periods.
- Grace Period: The claims experience has been adjusted to account for incidences of enrollees not paying premiums due during the first month of the 90-day grace period when the QHP is liable for paying claims.
- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.

- Projected cost of pediatric dental and vision benefits are included on all plans. The "Silver Core PPO Pathway X 5300" plan (HIOS ID: 86545CT1330010) also includes the projected cost of offering adult vision benefits.
- Benefits in excess of the essential health benefits in the projection period are included. Exhibit F provides details of additional non-EHB benefits.

• Trend Factors (cost/utilization)

- The annual pricing trend used in the development of the rates is 9.6%. Consistent with prior Individual ACA Rate Filings, the Individual pricing trend is developed by normalizing historical Small Group benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend, recognizing recent emerging unfavorable trend experience. Examples of such changes include contracting, cost of care initiatives, workdays, costs associated with Hepatitis C, compound drugs, average wholesale price, and expected introduction of generic drugs. The trend includes a volatility provision in accordance with Actuarial Standards of Practice. For projection, the experience period claims are trended 24.1 months from the midpoint of the experience period, which is June 28, 2015, to the midpoint of the projection period, which is July 1, 2017. Exhibit E has details.
- Projected trends include the estimated cost of the pharmaceutical Harvoni and other high-cost drugs for treating Hepatitis C. These cost estimates were based on Connecticut Individual claims experience, together with CDC recommendations, Industry and Anthem Inc. data.

7. Credibility Manual Rate Development

The experience period claims are 100% credible based on the credibility method used. Therefore, a manual rate was not used in the rate development.

8. Credibility of Experience

• Credibility Method Used

Based on an analysis of historical data, the standard for fully credible experience is 6,780 members.

To determine credibility, the following formula was used: $\sqrt{\frac{\text{Experience Period Members}}{6{,}780}}$

• Resulting Credibility Level Assigned to Base Period Experience

With 52,434 members, the credibility level assigned to the experience period claims is 100%.

9. Paid to Allowed Ratio

The 'Paid to Allowed Average Factor in Projection Period' reported in Worksheet 1, Section III of the URRT is equal to the ratio of member weighted average paid claims PMPM by plan to the member weighted average allowed claims PMPM by plan for the essential health benefits. The projected membership by plan used in the weighted average is reported in Worksheet 2, Section II of the URRT.

10. Risk Adjustment and Reinsurance

- Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:

  Experience period risk adjustments are estimated based on available 2015 information, including Wakely market study, CMS preliminary 2015 risk adjustment transfers and additional analysis of the market risk. Wakely Consulting collected demographic and risk information from carriers in the state and market, and calculated Anthem's relative risk to the market. The 'Net Amt of Risk Adj' reported in Worksheet 2, section III of the URRT reflect the risk adjustment transfers net of risk adjustment fees.

  Experience period reinsurance recoveries are estimated by applying the 2015 federal reinsurance parameters to member level incurred claims of the experience period. The 'Net Amt of Rein' reported in Worksheet 2, section III of the URRT reflect the reinsurance recoveries net of reinsurance contributions.

- Projected Risk Adjustments PMPM:

  Projection period risk adjustments are estimated based on the HHS payment transfer formula. The Wakely study and CMS preliminary 2015 risk adjustment transfers were used to develop the assumptions for the market level risk scores and the company's relative risk to the market. Any projected changes in population movements and demographics that may affect risk adjustments are also considered.

  The projected risk adjustment PMPMs reported in the URRT are net of risk adjustment fees, and on a paid claim basis. The projected amount applied to the development of Market Adjusted Index Rate is on an allowed claim basis. Exhibit C and Exhibit G provide details.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

  Beginning in 2017, the Federal reinsurance program will no longer be in effect. The projected reinsurance amount will be $0.

11. Non-Benefit Expenses and Profit & Risk

Non-benefit expenses and profit & risk margin are explained below. Exhibit H shows the amount for each component.

- Administrative Expense

  Administrative Expenses are expected to be consistent with historical levels and are developed utilizing the same methodology as previous filings. Maintenance costs are projected for 2017 based on 2015 actual expenses with adjustments made for expected changes in business operations.

- Quality Improvement Expense

  Quality Improvement initiatives include programs such as Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, and Health Information Technology Expenses for Health Care Quality Improvements. The expense assumptions are based on historical expense level adjusted for cost inflation and anticipated changes in the programs.

- Selling Expense

  Selling Expense represents projected broker commissions and bonuses associated with the broker distribution channel. Commissions will be paid for Off-Exchange plans but will not be paid for On-Exchange plans. Commission will be paid only for members enrolling during the Open Enrollment period.

- Specialty Expenses

  Specialty Expenses are projected administrative expenses for dental and vision coverage.

- Miscellaneous Item

  The miscellaneous items represent DOI fees and assements, including the assessment from the State of Connecticut to cover the cost of the Vaccine Immunization Program and the DPH assessment.

- Taxes and Fees

  - Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund.
  - ACA Insurer Fee: The health insurance industry is assessed a permanent fee, based on market share of net premium, which is not tax deductible. The tax impact of non-deductibility is captured in this fee. For 2017, this fee is 0% due to a one-year suspension by the federal government.
  - Exchange User Fee: The Exchange User Fee applies to Exchange business only, but the cost is spread across all plans in the market. The expected charge is estimated at 1.65% of premium. The resulting fee/percentage is applied evenly to all plans in the risk pool, both On and Off Exchange.

    The Exchange User Fee is applied as an adjustment to the Market Adjusted Index Rate at the market level as shown in Exhibit C.

  - Premium taxes, federal income taxes, and state income taxes are also included.

  The Risk Adjustment User Fee is reflected in the risk adjustment component of incurred claims, therefore not included in taxes and fees.

- Profit & Risk Margin

  Profit & risk margin is reflected on a post-tax basis as a percentage of premium.

12. Projected Loss Ratio

- Projected Federal MLR

  Exhibit I shows the projected Federal MLR for the products in this filing. The calculation is an estimate and is not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only a subset of Anthem's Individual business. The MLR for Anthem's entire book of Individual business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

13. Single Risk Pool

The single risk pool for this filing is established according to the requirements in 45 CFR 156.80. It reflects all covered lives for every non-grandfathered product/plan combination sold in the Connecticut Individual market by Anthem Health Plans, Inc.

14. Index Rate

- Experience Period Index Rate

  The experience period Index Rate is equal to the allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. The Index Rate reported in Worksheet 1, Section I, cell G17 of the URRT is $558.00, rounded to the nearest whole dollar as instructed. No benefits in excess of the essential health benefits have been included in this amount.

- Projection Period Index Rate

  The projection period Index Rate is equal to projected allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. It reflects the anticipated claim level of the projection period including impact from trend, benefit and demographics as described in Section 6 of this memo.

  The projected index rate is reported in Worksheet 1, Section III, cell V44 of the URRT and is also shown in Exhibit C. No benefits in excess of the essential health benefits have been included in this amount.

15. Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules. The three market-wide adjustments - Federal reinsurance program adjustment (ended for 2017), risk adjustment and Exchange user fee adjustment - were described previously in the memo. In compliance with URR Instructions, these adjustments were applied on an allowed basis in the development of the Market Adjusted Index Rate, while they were reported in the URRT on a paid basis. Exhibit C illustrates the development of the Market Adjusted Index Rate.

16. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. Exhibit J shows the development. The plan level modifiers are described below:

- AV and Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan, based on the AV metal value with an adjustment for utilization differences due to differences in cost sharing.
- Provider Network Adjustments: This is a multiplicative factor that adjusts for differences in projected claims cost due to different network discounts.
- Adjustments for Benefits in Addition to the Essential Health Benefits: This multiplicative factor adjusts for additional non-EHB benefits shown in Exhibit F.
- Catastrophic Plan Adjustment: This adjustment reflects the projected costs of the population eligible for catastrophic plans. The catastrophic adjustment factor is applied to catastrophic plans only; all other plans have an adjustment factor of 1.0.
- Adjustments for Distribution and Administrative Cost: This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H, with the exception of the Exchange user fee. The Exchange user fee has been included in the Market Adjusted Index Rate at the market level.

Experience Period Plan Adjusted Index Rate

The Plan Adjusted Index Rates for the experience period are reported in Worksheet 2, Section III of the URRT. They represent the Plan Adjusted Index Rates filed in 2015.

17. Calibration

The Plan Adjusted Index Rate is calibrated by the Age and Geographic factors so that the schedule of premiums rates for each plan can be further developed. Exhibit K shows both calibration factors.

• Age Curve Calibration

The age factors are based on the Default Federal Standard Age Curve. The age calibration adjustment is calculated as the member weighted average of the age factors, using the projected membership distribution by age, with an adjustment for the maximum of 3 child dependents under age 21. Under this methodology, the approximate average age rounded to the nearest whole number for the risk pool is 48.

- Geographic Factor Calibration

  The geographic factors are developed from historical claims experience. The geographic calibration adjustment is calculated as the member weighted average of the geographic factors, using the projected membership distribution by area.

18. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated by calibrating the Plan Adjusted Index Rate by the Age and Geographic calibration factors described above, and applying consumer specific age and geographic rating factors. Exhibit N has the sample rate calculations.

19. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values reported in Worksheet 2, Section I of the URRT are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. When applicable, benefits for plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

20. Actuarial Value Pricing Values

The Actuarial Value (AV) Pricing Values for each plan are reported in Worksheet 2, Section I of the URRT. The AV Pricing Value represents the cumulative effect of adjustments made to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate. Consistent with final Market Rules, utilization adjustments are made to account for member behavior variations based upon cost-share variations of the benefit design and not the health status of the member. The plan level allowable modifiers to the Index Rate are included in Exhibit J and described in Section 16 above.

21. Membership Projections

Membership projections are reported in Worksheet 2, Section IV of the URRT. They are based on historical and current enrollment, and expected new sales and lapses.

For Silver level plans in the Individual market, the portion of projected membership that will be eligible for cost-sharing reduction subsidies at each subsidy level are estimated from the enrollment data in the experience period. Exhibit O provides projected distributions for each plan.

22. Terminated Plans and Products

Exhibit P provides a listing of products from 2015 and 2016 that will be terminated prior to January 1, 2017.

23. Plan Type

The plan type for each plan reported in Worksheet 2, Section I of the URRT is consistent with the option chosen from the drop-down box.

24. Warning Alerts

There are warning alerts in cell A57 on Worksheet 2, Section III of the Unified Rate Review Template. This is because the Plan Adjusted Index Rates on Worksheet 2 are based on the distribution of ages, geography, and benefits that was projected when developing rates versus the Worksheet 1 average premium rate which reflects what actually emerged.

There are warning alerts in cells A68 and A73 on Worksheet 2, Section III of the Unified Rate Review Template. This is because Risk Adjustment receivable/payables and Reinsurance receivables for the experience period are not reflected in the Incurred Claims in Worksheet 1, but are reflected in the Incurred Claims in Worksheet 2, as directed in the URRT Instructions.

25. Reliance

In support of this rate development, various data and analyses were provided by other members of Anthem's actuarial staff, including data and analysis related to cost of care, valuation, and pricing. I have reviewed the data and analyses for reasonableness and consistency. I have relied on Wakely Consulting to provide the actuarial certification for the Unique Plan Design Supporting Documentation for the On Exchange Standard plans required by the Connecticut state exchange. I have also relied on Michele Archer, FSA, MAAA to provide the actuarial certification for the Unique Plan Design Supporting Documentation and Justification for plans included in this filing.

26. Actuarial Certification

I, Tu Nguyen, FSA, MAAA, am an actuary for Anthem. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The projected Index Rate is:

- In compliance with all applicable state and Federal statutes and regulations (45 CFR 156.80 and 147.102)
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Not excessive nor deficient

(2) The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 156.80(d)(2) were used to generate plan level rates.

(3) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV of the Part I Unified Rate Review Template is calculated in accordance with Actuarial Standards of Practice.

(4) The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

(5) The most recent AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate changes, for certification of Qualified Health Plans for Federally-Facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, used consistently, and only adjusted by the allowable modifiers. However, this Actuarial Memorandum does accurately describe the process used by the issuer to develop the rates.

Tu Nguyen, FSA, MAAA
Director & Actuary III

June 1, 2016
Date

Exhibit A - Non-Grandfathered Rate Changes

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

HIOS Plan Name	2017 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2016 HIOS Plan ID Mapping	Plan Category	Plan Specific Rate Change (excluding aging) {1}
Catastrophic HMO Pathway X Enhanced	86545CT1230005	On	Catastrophic	0.5556	Pathway X Enhanced	All	86545CT1230005	Renewing	31.3%
Bronze HMO Pathway X Enhanced	86545CT1230002	On	Bronze	0.7633	Pathway X Enhanced	All	86545CT1230002	Renewing	20.9%
Bronze HMO Pathway X Enhanced for HSA	86545CT1230001	On	Bronze	0.7516	Pathway X Enhanced	All	86545CT1230001	Renewing	28.3%
Gold HMO Pathway X Enhanced	86545CT1230004	On	Gold	1.0697	Pathway X Enhanced	All	86545CT1230004	Renewing	17.8%
Anthem HMO Catastrophic BlueCare 7150/0%	86545CT1310033	Off	Catastrophic	0.6385	BlueCare	All	86545CT1310033	Renewing	39.3%
Anthem Bronze HMO BlueCare 6200/12400/0% for HSA	86545CT1310019	Off	Bronze	0.8697	BlueCare	All	86545CT1310019	Renewing	35.0%
Anthem Silver HMO BlueCare 3850/0%	86545CT1310031	Off	Silver	0.9551	BlueCare	All	86545CT1310031	Renewing	16.5%
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	86545CT1310030	Off	Silver	0.9981	BlueCare	All	86545CT1310030	Renewing	27.0%
Anthem Silver HMO BlueCare Tiered 3550/6400/0%	86545CT1310042	Off	Silver	0.9289	BlueCare Tiered	All	86545CT1340014	New	28.3%
Anthem Gold HMO BlueCare 1500/0%	86545CT1310032	Off	Gold	1.2283	BlueCare	All	86545CT1310032	Renewing	24.4%
Anthem Gold HMO BlueCare Tiered 1650/3300/0%	86545CT1310041	Off	Gold	1.2904	BlueCare Tiered	All	None	New	0.0%
Bronze PPO Standard Pathway X	86545CT1330002	On	Bronze	0.7512	Pathway X	All	86545CT1330002	Renewing	18.9%
Bronze PPO Standard Pathway X for HSA	86545CT1330009	On	Bronze	0.7655	Pathway X	All	86545CT1330009	Renewing	33.5%
Silver PPO Pathway X	86545CT1330004	On	Silver	1.0254	Pathway X	All	86545CT1330004	Renewing	20.9%
Silver PPO Standard Pathway X	86545CT1330001	On	Silver	1.0234	Pathway X	All	86545CT1330001	Renewing	23.2%
Silver Core PPO Pathway X 5300	86545CT1330010	On	Silver	1.0238	Pathway X	All	None	New	0.0%
Gold PPO Standard Pathway X	86545CT1330003	On	Gold	1.3679	Pathway X	All	86545CT1330003	Renewing	35.9%
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	86545CT1340005	Off	Bronze	0.8149	Century Preferred	All	86545CT1340005	Renewing	39.4%
Anthem Bronze PPO Century Preferred 7150/0%	86545CT1340010	Off	Bronze	0.7731	Century Preferred	All	86545CT1340010	Renewing	39.8%
Anthem Silver PPO Century Preferred 2750	86545CT1340006	Off	Silver	0.9847	Century Preferred	All	86545CT1340006	Renewing	22.5%
Anthem Silver PPO Century Preferred 3000/6000 for HSA	86545CT1340011	Off	Silver	0.9655	Century Preferred	All	86545CT1340011	Renewing	29.8%
Anthem Gold PPO Century Preferred 1500/4500 for HSA	86545CT1340012	Off	Gold	1.1829	Century Preferred	All	86545CT1340012	Renewing	23.5%
Anthem Gold PPO Century Preferred 1900/0%	86545CT1340013	Off	Gold	1.3611	Century Preferred	All	86545CT1340013	Renewing	33.4%
Gold HMO Pathway X Enhanced, a Multi-State Plan	86545CT1470002	On	Gold	1.0864	Pathway X Enhanced	All	86545CT1470002	Renewing	27.3%
Silver PPO Pathway X, a Multi-State Plan	86545CT1480002	On	Silver	1.0249	Pathway X	All	86545CT1480002	Renewing	21.5%

NOTES:

{1} Plan level increases in rates do not include demographic changes in the population.

Exhibit B - Claims Experience for Rate Developments

Anthem Health Plans, Inc.
Individual

Experience Rate Claims Experience

Incurred January 1, 2015 through December 31, 2015
Paid through March 31, 2016

PAID CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			CSR	Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Receivable	Benefit Expense	Months	PMPM
$225,164,869	$65,366,333	$2,852,551	$35,328	$228,017,420	$65,401,661	$191	(8,341,105)	$285,078,168	629,207	**$453.08**

ALLOWED CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			CSR	Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Receivable	Benefit Expense	Months	PMPM
$277,765,810	$75,091,580	$3,411,982	$39,544	$281,177,792	$75,131,124	$191	N/A	$356,309,106	629,207	**$566.28**

Note

{1} The 'Experience Rate Claims Experience' above does not account for Rx Rebates; whereas, the claims shown in Worksheet 1, Section 1 of the URRT include them.

{2} Drug Claims are processed by an external vendor.

Exhibit C - Market Adjusted Index Rate Development

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

		Experience Rate	
1)	Starting Paid Claims PMPM	$453.08	Exhibit B
2)	x Normalization Factor	0.9752	Exhibit D
3)	= Normalized Claims	$441.84	= (1) x (2)
4)	x Benefit Changes	0.9970	Exhibit E
5)	x Morbidity Changes	0.9697	Exhibit E
6)	x Trend Factor	1.2013	Exhibit E
7)	x Other Cost of Care Impacts	1.0093	Exhibit E
8)	= Projected Paid Claim Cost	**$517.93**	= (3) x (4) x (5) x (6) x (7)
9)	Credibility Weight	100.00%	
10)	Blended Paid Claims	$517.93	
11)	- Non-EHBs Embedded in Line Item 1) Above	$1.01	
12)	= Projected Paid Claims, Excluding ALL Non-EHBs	$516.92	= (10) - (11)
13)	+ Rx Rebates	-$10.51	Exhibit F
14)	+ Additional EHBs	$3.36	Exhibit F
15)	= Projected Paid Claims for EHBs	$509.77	= (12) + (13) + (14)
16)	÷ Paid to Allowed Ratio	0.7593	
17)	**= Index Rate** {2}	**$671.37**	= (15) / (16)
18)	Reinsurance Contribution	$0.00	Exhibit G
19)	Expected Reinsurance Payments	$0.00	Exhibit G
20)	Risk Adjustment Fee	$0.13	Exhibit G
21)	Risk Adjustment Net Transfer	-$31.21	Exhibit G
22)	Exchange User Fee	$9.53	Exhibit H
23)	**= Market Adjusted Index Rate** {3}	$642.99	= (17)+[(18)+(19)+(20)+(21)+(22)] ÷ (16)

NOTE:

{1} Factors above are detailed in subsequent exhibits

{2} Index Rate is Projected Allowed Claims for EHBs only

{3} The Market Adjusted Index Rate is the same for all plans in the single risk pool

Exhibit D - Normalization Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

	Average Claim Factors - Experience Rate		
	Experience Period Population	Future Population	Normalization Factor [1]
Age/Gender	1.0318	1.0316	0.9998
Area/Network	0.9221	0.9163	0.9937
Benefit Plan	0.7066	0.6936	0.9816
Total			**0.9752**

Note

{1} Nomalization Factor = Future Population Factor / Experience Period Population Factor

Exhibit E - Projection Period Adjustments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Impact of Changes Between Experience Period and Projection Period:		
		Experience Rate
Benefit changes		
	EHB Changes	1.0018
	Network Adjustments	0.9952
	Total Benefit Changes	0.9970
Morbidity changes		
	Total Morbidity Changes	0.9697
Trend & Other Cost of Care impacts		
	Annual Medical/Rx Trend Rate	9.6%
	# Months of Projection	24.1
	Trend Factor	1.2013
	Other Cost of Care:	
	Medical Management	1.0011
	Induced Demand for CSR	1.0010
	Grace Period	1.0072
	Total other Cost of Care Impacts	1.0093

Note

{1} Explanation of the factors above is provided in the Actuarial Memorandum

Exhibit F - Other Claim Adjustments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Other Claim Adjustments	
	PMPM
Rx Rebates	($10.51)
Additional EHBs	
Pediatric Dental	$3.08
Pediatric Vision	$0.28
Total - Additional EHBs	$3.36
Additional non-EHBs	
CCP Packages, Adult Dental, Adult Vision	$0.01
Non-EHB pmpm (in experience)	$0.04
Elective Abortion (if Non-EHB)	$0.97
Total - Additional Non-EHBs	$1.02

NOTES:

{1} This exhibit includes projected claims from lines 13 & 14 of Exhibit C and additional non EHBs.

Exhibit G - Risk Adjustment and Reinsurance - Contributions and Payments

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Risk Adjustment:		
PMPM	**User Fee** {1}	**Net Transfer** {2}
Federal Program	$0.13	($31.21)

Reinsurance: {3}		
PMPM	**Contributions Made**	**Expected Receipts**
Federal Program	$0.00	$0.00

Grand Total of All Risk Mitigation Programs	($31.08)

NOTES:

{1} For 2017, HHS established a per capita annual user fee rate of $1.56 per year or $0.13 per-enrollee-per-month.

{2} Projected risk adjustment transfer amount is explained in the Memorandum "Risk Adjustment and Reinsurance" Section.

{3} Federal Reinsurance Program is no longer applicable starting in 2017.

Exhibit H - Non-Benefit Expenses and Profit & Risk

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

	Expenses Applied As a PMPM Cost	Expenses Applied as a % of Premium [1]	Expenses Expressed as a PMPM [4]
Administrative Expenses			
Administrative Costs	$32.42		$32.42
Quality Improvement Expense	$6.89		$6.89
Selling Expense		0.53%	$3.08
Specialty Expenses	$0.53		$0.53
Misc Admin (PMPM) [5]	$2.37		$2.37
Total Administrative Expenses	**$42.21**	**0.53%**	**$45.29**
Taxes and Fees			
PCORI Fee	$0.20		$0.20
ACA Insurer Fee		0.00%	$0.00
Exchange User Fee		1.65%	$9.53
Premium Tax		1.75%	$10.11
MLR-Deductible Federal/State Income Taxes [2]		1.75%	$10.11
Misc Taxes & Fees (% prem) [6]		0.66%	$3.81
Total Taxes and Fees	**$0.20**	**5.81%**	**$33.75**
Profit and Risk Margin [3]		3.25%	$18.77
Total Non-Benefit Expenses, Profit, and Risk	**$42.41**	**9.59%**	**$97.81**

NOTES:

{1} The sum of the rounded percentages shown may not equal the total at the bottom of the table due to rounding.

{2} Includes only those income taxes which are deductible from the MLR denominator; in particular, Federal income taxes on investment income are excluded.

{3} Profit and Risk Margin shown here is post-tax profit, net of those federal and state income taxes which are deductible from the MLR denominator.

{4} Anthem's Non-Benefit Expenses are applied in both PMPM and % of Premium as shown above. The last column expresses all non-benefit Expenses in PMPM only.

{5} Includes charge for State of Connecticut Vaccine Immunization Program and the DPH assessment.

{6} Includes charges for DOI Fees and Assessments.

Exhibit I - Federal MLR Estimated Calculation

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Numerator:		
Incurred Claims {1}	$510.79	Exhibit C (Line 15) + Exhibit F (Total Non-EHBs)
+ Quality Improvement Expense	$6.89	Exhibit H
+ Risk Corridor Contributions	$0.00	
+ Risk Adjustment Net Transfer	-$31.21	Exhibit G
+ Reinsurance Receipts	$0.00	Exhibit G
+ Risk Corridor Receipts	$0.00	
+ Reduction to Rx Incurred Claims (ACA MLR)	-$11.45	Footnote {3}
= *Estimated* Federal MLR Numerator	$475.03	
Denominator:		
Premiums {2}	$577.52	Incurred Claims + Exhibit G (Total) + Exhibit H (Total)
- Federal and State Taxes	$10.11	Exhibit H (Federal/State Income Taxes)
- Premium Taxes	$10.11	Exhibit H (Premium Tax)
- Risk Adjustment User Fee	$0.13	Exhibit G
- Reinsurance Contributions	$0.00	Exhibit G
- Misc Admin (PMPM)	$2.37	Exhibit H
- Misc Taxes & Fees (% of Premium)	$3.81	Exhibit H
- Licensing and Regulatory Fees	$9.73	Exhibit H (PCORI, ACA and Exchange Fees)
= *Estimated* Federal MLR Denominator	$541.26	
***Estimated* Federal MLR**	**87.76%**	

NOTES:

{1} Incurred Claims = Projected Paids Claims for EHB (Exhibit C Line 15) + additional non EHBs (Exhibit F Total Non-EHBs)

{2} Premiums = Incurred Claims in this exhibit + Risk Mitigation Programs in Exhibit G + Non-Benefit Expenses and Profit & Risk Margin in Exhibit H

{3} This is the amount of 2017 pharmacy claims that are attributable to PBM Administrative Expenses (i.e. the "retail spread" or "pharmacy claims margin"). It is calculated by applying the 3rd party margin percentage to the 2017 projected Pharmacy claims including projected rebates.

{4} The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

* The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.

* Not all numerator/denominator components are captured above (for example, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).

* Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.

* Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule.

Exhibit J - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit C)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs {2}	Plan Adjusted Index Rate {3}	Calibration Factor {4}	Consumer Adjusted Premium Rate {5}
Catastrophic HMO Pathway X Enhanced	86545CT1230005	$642.99	0.5447	0.9516	1.0034	0.8169	$47.66	$320.87	1.6332	$196.47
Bronze HMO Pathway X Enhanced	86545CT1230002	$642.99	0.6122	0.9516	1.0025	1.0000	$65.29	$440.83	1.6332	$269.92
Bronze HMO Pathway X Enhanced for HSA	86545CT1230001	$642.99	0.6028	0.9516	1.0025	1.0000	$64.30	$434.06	1.6332	$265.77
Gold HMO Pathway X Enhanced	86545CT1230004	$642.99	0.8589	0.9516	1.0018	1.0000	$91.30	$617.79	1.6332	$378.27
Anthem HMO Catastrophic BlueCare 7150/0%	86545CT1310033	$642.99	0.5447	1.0761	1.0034	0.8169	$59.79	$368.74	1.6332	$225.78
Anthem Bronze HMO BlueCare 6200/12400/0% for HSA	86545CT1310019	$642.99	0.6069	1.0761	1.0025	1.0000	$81.25	$502.25	1.6332	$307.52
Anthem Silver HMO BlueCare 3850/0%	86545CT1310031	$642.99	0.6667	1.0761	1.0023	1.0000	$89.18	$551.56	1.6332	$337.72
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	86545CT1310030	$642.99	0.6969	1.0761	1.0022	1.0000	$93.19	$576.43	1.6332	$352.95
Anthem Silver HMO BlueCare Tiered 3550/6400/0%	86545CT1310042	$642.99	0.6484	1.0761	1.0024	1.0000	$86.76	$536.47	1.6332	$328.48
Anthem Gold HMO BlueCare 1500/0%	86545CT1310032	$642.99	0.8581	1.0761	1.0018	1.0000	$114.56	$709.39	1.6332	$434.36
Anthem Gold HMO BlueCare Tiered 1650/3300/0%	86545CT1310041	$642.99	0.9016	1.0761	1.0017	1.0000	$120.32	$745.24	1.6332	$456.31
Bronze PPO Standard Pathway X	86545CT1330002	$642.99	0.5965	0.9611	1.0026	1.0000	$64.26	$433.82	1.6332	$265.63
Bronze PPO Standard Pathway X for HSA	86545CT1330009	$642.99	0.6078	0.9611	1.0025	1.0000	$65.48	$442.06	1.6332	$270.67
Silver PPO Pathway X	86545CT1330004	$642.99	0.8150	0.9611	1.0019	1.0000	$87.54	$592.19	1.6332	$362.59
Silver PPO Standard Pathway X	86545CT1330001	$642.99	0.8135	0.9611	1.0019	1.0000	$87.37	$591.05	1.6332	$361.90
Silver Core PPO Pathway X 5300	86545CT1330010	$642.99	0.8108	0.9611	1.0038	1.0000	$88.26	$591.27	1.6332	$362.03
Gold PPO Standard Pathway X	86545CT1330003	$642.99	1.0880	0.9611	1.0014	1.0000	$116.61	$789.98	1.6332	$483.70
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	86545CT1340005	$642.99	0.5629	1.0869	1.0027	1.0000	$76.16	$470.60	1.6332	$288.15
Anthem Bronze PPO Century Preferred 7150/0%	86545CT1340010	$642.99	0.5339	1.0869	1.0029	1.0000	$72.29	$446.49	1.6332	$273.39
Anthem Silver PPO Century Preferred 2750	86545CT1340006	$642.99	0.6807	1.0869	1.0023	1.0000	$91.94	$568.70	1.6332	$348.21
Anthem Silver PPO Century Preferred 3000/6000 for HSA	86545CT1340011	$642.99	0.6673	1.0869	1.0023	1.0000	$90.15	$557.58	1.6332	$341.40
Anthem Gold PPO Century Preferred 1500/4500 for HSA	86545CT1340012	$642.99	0.8181	1.0869	1.0019	1.0000	$110.35	$683.17	1.6332	$418.30
Anthem Gold PPO Century Preferred 1900/0%	86545CT1340013	$642.99	0.9417	1.0869	1.0017	1.0000	$126.89	$786.06	1.6332	$481.30
Gold HMO Pathway X Enhanced, a Multi-State Plan	86545CT1470002	$642.99	0.8738	0.9516	1.0001	1.0000	$92.72	$627.44	1.6332	$384.18
Silver PPO Pathway X, a Multi-State Plan	86545CT1480002	$642.99	0.8162	0.9611	1.0001	1.0000	$87.50	$591.93	1.6332	$362.43

Notes:

{1} This adjustment reflects the projected costs of the population eligible for catastrophic plans.

{2} This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H, with the exception of the Exchange user fee. The Exchange user fee has been included in the Market Adjusted Index Rate at the market level.

{3} The Plan Adjusted Index Rate is calculated by multiplying the Market Adjusted Index Rate by the AV and cost sharing, provider network, benefits in addition to the EHBs, and catastrophic plan adjustments and then adding the administrative costs. The Plan Adjusted Index Rate can also be described as a Plan Level Required Premium.

{4} See Exhibit K - Calibration.

{5} The Consumer Adjusted Premium Rate is equal to 'Plan Adjusted Index Rate' divided by 'Calibration Factor'

Exhibit K - Calibration

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Average rating factors for 2017 population:	
	Calibration Factors
Age	1.6638
Area	0.9816
Total Calibration Factor{1}	1.6332

NOTES:

{1} Total Calibration factor was used in Exhibit J.

Exhibit L - Age and Tobacco Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

	Age Factors	Tobacco Factors
Age	**2017**	**2017**
0-17	0.635	1.000
18	0.635	1.000
19	0.635	1.000
20	0.635	1.000
21	1.000	1.000
22	1.000	1.000
23	1.000	1.000
24	1.000	1.000
25	1.004	1.000
26	1.024	1.000
27	1.048	1.000
28	1.087	1.000
29	1.119	1.000
30	1.135	1.000
31	1.159	1.000
32	1.183	1.000
33	1.198	1.000
34	1.214	1.000
35	1.222	1.000
36	1.230	1.000
37	1.238	1.000
38	1.246	1.000
39	1.262	1.000
40	1.278	1.000
41	1.302	1.000
42	1.325	1.000
43	1.357	1.000
44	1.397	1.000
45	1.444	1.000
46	1.500	1.000
47	1.563	1.000
48	1.635	1.000
49	1.706	1.000
50	1.786	1.000
51	1.865	1.000
52	1.952	1.000
53	2.040	1.000
54	2.135	1.000
55	2.230	1.000
56	2.333	1.000
57	2.437	1.000
58	2.548	1.000
59	2.603	1.000
60	2.714	1.000
61	2.810	1.000
62	2.873	1.000
63	2.952	1.000
64+	3.000	1.000

NOTES:
The weighted average of these factors for the entire risk pool included in this rate filing is provided in Exhibit K.

Exhibit M - Area Factors

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Rating Area Description	2017 Area Rating Factor	2016 Area Rating Factor	Change
Fairfield	1.1200	1.1000	1.8%
Hartford	0.9200	0.8700	5.7%
Litchfield	0.9200	0.8700	5.7%
Middlesex	1.0100	0.9500	6.3%
New Haven	0.9500	0.9500	0.0%
New London	0.9200	0.8700	5.7%
Tolland	0.9200	0.8700	5.7%
Windham	0.9200	0.8700	5.7%
Out of Area	1.0000	1.0000	0.0%

NOTES:

{1} The weighted average of these factors for the entire risk pool included in this rate filing is provided in Exhibit K.

Exhibit N - Sample Rate Calculation

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Name: **John Doe**
Effective Date: **1/1/2017**
On/Off Exchange: Off
Metal Level: Bronze
Plan ID: 86545CT1310019
Rating Area: 01

Family Members Covered:

	Age
Subscriber	47
Spouse	42
Child (age 21+)	25
Child #1	20
Child #2	16

Calculation of Monthly Premium:

Consumer Adjusted Premium Rate	$307.52	Exhibit J
x Area Factor	1.1200	Exhibit M
Rate Adjusted for Area =	$344.43	

Age Factors: Exhibit L

	Age Factor
Subscriber	1.563
Spouse	1.325
Child (age 21+)	1.004
Child #1	0.635
Child #2	0.635

Final Monthly Premium PMPM:

	PMPM
Subscriber	$538.34
Spouse	$456.37
Child (age 21+)	$345.81
Child #1	$218.71
Child #2	$218.71
TOTAL	**$1,777.94**

NOTES:

As per the Market Reform Rule, when computing family premiums no more than the three oldest covered children under the age of 21 are taken into account whereas the premiums associated with each child age 21+ are included.

Minor rate variances may occur due to differences in rounding methodology.

Exhibit O - Membership Projections for Cost-Sharing Reductions

Anthem Health Plans, Inc.
Individual

Rates Effective January 1, 2017

Silver Plan	Projected Membership by Subsidy Level:			
HIOS Standard Component Plan ID	100-150%	150%-200%	200%-250%	Standard
86545CT1310031	0	0	0	1,470
86545CT1310030	0	0	0	2,100
86545CT1310042	0	0	0	1,050
86545CT1330004	444	508	321	1,352
86545CT1330001	2,844	3,250	2,055	8,651
86545CT1330010	89	102	64	270
86545CT1340006	0	0	0	2,310
86545CT1340011	0	0	0	630
86545CT1480002	195	223	141	596

Exhibit P - Terminated Products

Anthem Health Plans, Inc.
Individual

Effective January 1, 2017

Following are the products that will be terminated prior to the effective date:

This includes products that have experience included in the URRT during the experience period and any products that were not in effect during the experience period but were made available thereafter.

Post ACA Terminated Products	
HIOS Product ID	**HIOS Product Name**
None	None

Anthem

Anthem Health Plans – Connecticut
Actuarial Certification

I, Tu Nguyen, FSA, MAAA, am a Director and Actuary III for Anthem Health Plans. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. I certify that to the best of my knowledge and judgment that the enclosed rate filing is in compliance with the applicable laws, regulations and bulletins of the State of Connecticut and is in accordance with generally accepted actuarial principles. In my opinion, these rates are not excessive, inadequate, or unfairly discriminatory. My determination was based on information provided by other employees of Anthem Health Plans, and my own analysis.

Tu Nguyen, FSA, MAAA

Director & Actuary III

June 1, 2016

Unified Rate Review v3.3

Company Legal Name: **Anthem Health Plans, Inc.** State: **CT**
HIOS Issuer ID: **86545** Market: **Individual**
Effective Date of Rate Change(s): **1/1/2017**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2015 to 12/31/2015

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$298,699,430	$474.72	100.00%
Incurred Claims in Experience Period	$279,876,943	444.81	93.70%
Allowed Claims:	$351,107,881	558.02	117.55%
Index Rate of Experience Period		$558.00	
Experience Period Member Months	629,207		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2017 to 12/31/2017 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period				Annualized Trend Factors	Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**		**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Days	348.53	$3,985.42	$115.75	0.970	1.061	1.025	1.039		364.54	$4,443.87	$135.00	0.00	$0.00	$0.00
Outpatient Hospital	Visits	2,058.27	975.66	167.35	0.970	1.061	1.025	1.039		2,152.79	1,087.89	195.17	0.00	0.00	0.00
Professional	Visits	9,844.31	182.24	149.50	0.970	1.061	1.025	1.039		10,296.43	203.21	174.36	0.00	0.00	0.00
Other Medical	Visits	728.19	219.36	13.31	0.970	1.061	1.025	1.039		761.63	244.59	15.52	0.00	0.00	0.00
Capitation	Benefit Period	12,000.00	0.00	0.00	0.970	1.061	1.003	1.003		11,717.73	0.00	0.00	0.00	0.00	0.00
Prescription Drug	Prescriptions	12,269.18	109.64	112.10	0.970	1.061	1.088	1.058		13,310.34	137.64	152.67	0.00	0.00	0.00
Total				$558.02								$672.71			$0.00

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100.00%	0.00%	$672.71	$457,713,046
Paid to Allowed Average Factor in Projection Period			0.759	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$510.79	$347,541,516
Projected Risk Adjustments PMPM			31.08	21,146,101
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$479.71	$326,395,415
Projected ACA reinsurance recoveries, net of rein prem, PMPM			0.00	0
Projected Incurred Claims			$479.71	$326,395,415
Administrative Expense Load		7.84%	45.29	30,817,967
Profit & Risk Load		3.25%	18.77	12,767,999
Taxes & Fees		5.84%	33.75	22,964,134
Single Risk Pool Gross Premium Avg. Rate, PMPM			$577.52	$392,945,514
Index Rate for Projection Period			$671.37	
% increase over Experience Period			21.65%	
% Increase, annualized:			10.30%	
Projected Member Months				680,400

Product-Plan Data Collection

Company Legal Name: **Anthem Health Plans, Inc.** State:
HIOS Issuer ID: **86545** Market:
Effective Date of Rate Change(s): **1/1/2017**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		HMO On Exchange				HMO Off Exchange					
Product ID:		86545CT123				86545CT131					
Metal:		Catastrophic	Bronze	Bronze	Gold	Catastrophic	Bronze	Silver	Silver	Silver	Gold
AV Metal Value		0.594	0.620	0.619	0.808	0.594	0.620	0.720	0.717	0.720	0.808
AV Pricing Value		0.499	0.686	0.675	0.961	0.573	0.781	0.858	0.896	0.834	1.103
Plan Category		Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	New	Renewing
Plan Type:		HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Plan Name		Catastrophic HMO Pathway X Enhanced	Bronze HMO Pathway X Enhanced	Bronze HMO Pathway X Enhanced for HSA	Gold HMO Pathway X Enhanced	Anthem HMO Catastrophic BlueCare 7150/0%	HMO BlueCare 6200/12400/0% for HSA	Anthem Silver HMO BlueCare 3850/0%	HMO BlueCare 3500/7000/0% for HSA	HMO BlueCare Tiered 3550/6400/0%	Anthem Gold HMO BlueCare 1500/0%
Plan ID (Standard Component ID):		86545CT1230005	86545CT1230002	86545CT1230001	86545CT1230004	86545CT1310033	86545CT1310019	86545CT1310031	86545CT1310030	86545CT1310042	86545CT1310032
Exchange Plan?		Yes	Yes	Yes	Yes	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2		-3.63%				-0.06%					
Historical Rate Increase - Calendar Year - 1		2.38%				0.34%					
Historical Rate Increase - Calendar Year 0		24.18%				27.01%					
Effective Date of Proposed Rates		1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017
Rate Change % (over prior filing)		31.28%	20.90%	28.34%	17.81%	39.29%	35.01%	16.50%	27.00%	28.32%	24.37%
Cum'tive Rate Change % (over 12 mos prior)		31.28%	20.90%	28.34%	17.81%	39.29%	35.01%	16.50%	27.00%	28.32%	24.37%
Proj'd Per Rate Change % (over Exper. Period)		35.78%	22.28%	37.62%	16.41%	44.06%	45.28%	13.23%	29.28%	#DIV/0!	23.40%
Product Rate Increase %		24.18%				27.01%					

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	86545CT1230005	86545CT1230002	86545CT1230001	86545CT1230004	86545CT1310033	86545CT1310019	86545CT1310031	86545CT1310030	86545CT1310042	86545CT1310032
Inpatient	$27.88	$17.18	$21.52	$27.44	$24.20	$20.07	$33.63	$17.20	$28.06	$27.65	$27.03
Outpatient	$40.31	$24.83	$31.11	$39.67	$34.99	$29.02	$48.61	$24.87	$40.57	$39.97	$39.08
Professional	$36.01	$22.19	$27.79	$35.44	$31.26	$25.93	$43.43	$22.22	$36.24	$35.71	$34.91
Prescription Drug	$31.53	$19.43	$24.34	$31.03	$27.37	$22.70	$38.03	$19.46	$31.74	$31.27	$30.57
Other	$3.21	$1.98	$2.47	$3.16	$2.78	$2.31	$3.87	$1.98	$3.23	$3.18	$3.11
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	-$11.67	-$31.15	-$20.52	-$23.68	-$9.61	-$25.67	-$14.96	-$4.74	-$6.93	-$10.30	$3.17
Taxes & Fees	-$11.38	-$7.63	-$8.31	-$9.65	-$10.66	-$9.55	-$12.15	-$8.79	-$12.05	-$11.61	-$13.98
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$115.87	$46.82	$78.40	$103.39	$100.32	$64.81	$140.45	$72.20	$120.87	$115.87	$123.88
Member Cost Share Increase	$54.10	$68.15	$73.95	$86.26	$52.06	$82.44	$104.89	$62.65	$56.96	$47.72	$63.28
Average Current Rate PMPM	$453.76	$149.71	$375.09	$364.79	$563.42	$164.96	$401.15	$437.67	$447.61	$409.15	$508.30
Projected Member Months	680,400	8,820	9,450	28,350	11,340	6,300	37,800	17,640	25,200	12,600	39,060

Section III: Experience Period Information

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	86545CT1230005	86545CT1230002	86545CT1230001	86545CT1230004	86545CT1310033	86545CT1310019	86545CT1310031	86545CT1310030	86545CT1310042	86545CT1310032
OK	$ 474.72		Plan Adjusted Index Rate	$442.38	$236.31	$360.50	$315.41	$530.68	$255.97	$345.71	$487.11	$445.89	$0.00	$574.89
OK	629,207	Premium Information	Member Months	629,206	9,211	11,024	34,955	14,563	5,242	14,112	6,657	32,960	0	51,985
WARNING	$298,699,430		Total Premium (TP)	$278,345,369	$2,176,626	$3,974,197	$11,025,096	$7,728,263	$1,341,780	$4,878,613	$3,242,661	$14,696,521	$0	$29,885,654
			EHB Percent of TP, [see instructions]	99.84%	99.66%	99.70%	99.66%	99.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
			state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TP	0.16%	0.34%	0.30%	0.34%	0.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
OK	$351,107,881		Total Allowed Claims (TAC)	$351,107,823	$809,238	$3,054,800	$9,509,175	$15,051,705	$498,943	$4,304,410	$3,311,404	$16,200,230	$0	$32,962,627
			EHB Percent of TAC, [see instructions]	99.98%	100.00%	99.99%	99.99%	100.00%	100.00%	100.00%	99.85%	100.00%	100.00%	99.99%
			state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TAC	0.02%	0.00%	0.01%	0.01%	0.00%	0.00%	0.00%	0.15%	0.00%	0.00%	0.01%
		Claims Information	Allowed Claims which are not the issuer's obligation:	$128,257,618	$438,205	$178,518	-$258,933	$7,679,911	$418,616	-$36,910	$1,485,095	$3,621,333	$0	$13,329,928
			Portion of above payable by HHS's funds on behalf of insured person, in dollars	$8,341,105	$0	$7,110	$15,587	$0	$0	$0	$0	$0	$0	$0
			Portion of above payable by HHS on behalf of insured person, as %	6.50%	0.00%	3.98%	-6.02%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/0!	0.00%
WARNING	$279,876,943		Total Incurred claims, payable with issuer funds	$222,850,205	$371,033	$2,876,282	$9,768,108	$7,371,794	$80,326	$4,341,320	$1,826,309	$12,578,897	$0	$19,632,699
			Net Amt of Rein	$34,037,291.55	$13,427.05	$183,404.87	$908,291.58	$1,969,252.52	-$10,669.37	$409,900.77	$303,297.39	$1,134,448.46	$0.00	$3,034,812.84
			Net Amt of Risk Adj	$20,712,549.72	-$103,453.40	-$1,076,392.89	-$4,733,865.75	$4,101,471.58	$102,297.16	-$2,106,570.15	$375,411.40	-$1,530,251.21	$0.00	$5,294,674.28
WARNING	$ 444.81		Incurred Claims PMPM	$354.18	$40.28	$260.91	$279.45	$506.20	$15.32	$307.63	$274.34	$381.64	#DIV/0!	$377.66
OK	$ 558.02		Allowed Claims PMPM	$558.02	$87.86	$277.10	$272.04	$1,033.56	$95.18	$305.02	$497.43	$491.51	#DIV/0!	$634.08
			EHB portion of Allowed Claims, PMPM	$557.92	$87.86	$277.07	$272.02	$1,033.56	$95.18	$305.02	$496.68	$491.50	#DIV/0!	$634.04

Section IV: Projected (12 months following effective date)

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	86545CT1230005	86545CT1230002	86545CT1230001	86545CT1230004	86545CT1310033	86545CT1310019	86545CT1310031	86545CT1310030	86545CT1310042	86545CT1310032
OK	$ 577.52		Plan Adjusted Index Rate	$577.52	$320.87	$440.83	$434.06	$617.79	$368.74	$502.25	$551.56	$576.43	$536.47	$709.39
OK	680,400	Premium Information	Member Months	680,400	8,820	9,450	28,350	11,340	6,300	37,800	17,640	25,200	12,600	39,060
OK	$392,945,514		Total Premium (TP)	$392,944,608	$2,830,049	$4,165,813	$12,305,492	$7,005,693	$2,323,062	$18,984,956	$9,729,564	$14,526,156	$6,759,544	$27,708,791
			EHB Percent of TP, [see instructions]	99.82%	99.68%	99.76%	99.76%	99.83%	99.72%	99.79%	99.81%	99.82%	99.80%	99.85%
			state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TP	0.18%	0.32%	0.24%	0.24%	0.17%	0.28%	0.21%	0.19%	0.18%	0.20%	0.15%
OK	457,713,046		Total Allowed Claims (TAC)	$459,092,249	$4,116,532	$5,833,798	$17,567,560	$7,690,750	$3,325,094	$26,537,130	$11,811,208	$17,277,401	$8,147,189	$29,964,923
			EHB Percent of TAC, [see instructions]	99.81%	99.68%	99.76%	99.76%	99.83%	99.72%	99.79%	99.81%	99.82%	99.80%	99.85%
			state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TAC	0.19%	0.32%	0.24%	0.24%	0.17%	0.28%	0.21%	0.19%	0.18%	0.20%	0.15%
		Claims Information	Allowed Claims which are not the issuer's obligation	$132,699,739	$1,753,808	$2,354,137	$7,289,150	$1,836,724	$1,416,624	$10,933,642	$3,813,711	$5,336,702	$2,591,151	$7,183,448
			Portion of above payable by HHS's funds on behalf of insured person, in dollars	$14,779,842	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Portion of above payable by HHS on behalf of insured person, as %	11.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
OK	326,395,415		Total Incurred claims, payable with issuer funds	$326,392,510	$2,362,724	$3,479,661	$10,278,410	$5,854,026	$1,908,470	$15,603,489	$7,997,496	$11,940,699	$5,556,038	$22,781,475
#DIV/0!	-		Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Net Amt of Risk Adj	$21,146,832	$153,080	$225,446	$665,934	$379,280	$123,649	$1,010,943	$518,154	$773,633	$359,973	$1,476,002
OK	$ 479.71		Incurred Claims PMPM	$479.71	$267.88	$368.22	$362.55	$516.23	$302.93	$412.79	$453.37	$473.84	$440.96	$583.24
OK	$ 672.71		Allowed Claims PMPM	$674.74	$466.73	$617.33	$619.67	$678.20	$527.79	$702.04	$669.57	$685.61	$646.60	$767.15
			EHB portion of Allowed Claims, PMPM	$673.48	$465.23	$615.85	$618.18	$677.04	$526.31	$700.57	$668.30	$684.38	$645.31	$766.00

CT

Individual

	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF
12					PPO On Exchange						PPO Off Exchange					
13					86545CT133						86545CT134					
14	Gold	Bronze	Bronze	Bronze	Bronze	Bronze	Silver	Silver	Silver	Gold	Bronze	Bronze	Silver	Silver	Gold	Gold
15	0.791	0.592	0.599	0.602	0.620	0.620	0.712	0.720	0.688	0.811	0.616	0.594	0.715	0.698	0.783	0.805
16	1.159	0.010	0.010	0.010	0.675	0.688	0.921	0.919	0.920	1.229	0.732	0.694	0.884	0.867	1.062	1.223
17	New	Terminated	Terminated	Terminated	Renewing	Renewing	Renewing	Renewing	New	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing
18	HMO		HMO	HMO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
	HMO BlueCare			Anthem HMO	Bronze PPO	Bronze PPO		Silver PPO		Gold PPO	PPO Century	PPO Century	Anthem Silver	PPO Century	Century Preferred	Anthem Gold PPO
	Tiered	Anthem HMO	Anthem HMO	BlueCare 0% for	Standard Pathway	Standard Pathway	Silver PPO	Standard Pathway	Silver Core PPO	Standard Pathway	Preferred	Preferred	PPO Century	Preferred	1500/4500 for	Century Preferred
19	1650/3300/0%	BlueCare 6000/0%	BlueCare 5500/0%	HSA	X	X for HSA	Pathway X	X	Pathway X 5300	X	5700/11400/20%	7150/0%	Preferred 2750	3000/6000 for	HSA	1900/0%
20	86545CT1310041	86545CT1310024	86545CT1310020	86545CT1310018	86545CT1330002	86545CT1330009	86545CT1330004	86545CT1330001	86545CT1330010	86545CT1330003	86545CT1340005	86545CT1340010	86545CT1340006	86545CT1340011	86545CT1340012	86545CT1340013
21	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
22					0.63%						-1.75%					
23					2.77%						5.97%					
24					25.87%						32.43%					
25	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017
26	0.00%	0.00%	0.00%	0.00%	18.93%	33.46%	20.95%	23.24%	0.00%	35.91%	39.41%	39.83%	22.51%	29.75%	23.50%	33.43%
27	0.00%	0.00%	0.00%	0.00%	18.93%	33.46%	20.95%	23.24%	0.00%	35.91%	39.41%	39.83%	22.51%	29.75%	23.50%	33.43%
28	#DIV/0!	-100.00%	-100.00%	-100.00%	26.44%	33.64%	25.00%	24.97%	#DIV/0!	43.40%	50.55%	#DIV/0!	28.05%	#DIV/0!	#DIV/0!	#DIV/0!
29					25.87%						32.43%					
30																
31																
32																
33	86545CT1310041	86545CT1310024	86545CT1310020	86545CT1310018	86545CT1330002	86545CT1330009	86545CT1330004	86545CT1330001	86545CT1330010	86545CT1330003	86545CT1340005	86545CT1340010	86545CT1340006	86545CT1340011	86545CT1340012	86545CT1340013
34	$0.00	$0.00	$0.00	$0.00	$20.27	$30.59	$28.71	$28.51	$0.00	$46.54	$35.29	$33.33	$23.09	$28.28	$24.43	$37.32
35	$0.00	$0.00	$0.00	$0.00	$29.31	$44.23	$41.50	$41.21	$0.00	$67.28	$51.02	$48.18	$33.38	$40.88	$35.32	$53.96
36	$0.00	$0.00	$0.00	$0.00	$26.18	$39.51	$37.08	$36.82	$0.00	$60.11	$45.58	$43.05	$29.82	$36.52	$31.55	$48.20
37	$0.00	$0.00	$0.00	$0.00	$22.93	$34.60	$32.46	$32.24	$0.00	$52.63	$39.91	$37.69	$26.11	$31.98	$27.63	$42.21
38	$0.00	$0.00	$0.00	$0.00	$2.33	$3.52	$3.30	$3.28	$0.00	$5.35	$4.06	$3.83	$2.66	$3.25	$2.81	$4.29
39	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
40	$0.00	$0.00	$0.00	$0.00	-$20.19	-$25.20	-$12.22	-$12.85	$0.00	-$6.83	-$18.97	-$20.68	-$5.87	-$9.40	$1.64	$5.06
41	$0.00	$0.00	$0.00	$0.00	-$7.78	-$10.78	-$11.15	-$11.55	$0.00	-$19.80	-$12.26	-$11.67	-$10.79	-$12.41	-$13.24	-$18.49
42	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
43	$0.00	$0.00	$0.00	$0.00	$73.06	$116.46	$119.67	$117.67	$0.00	$205.28	$144.65	$133.73	$98.40	$119.09	$110.15	$172.56
44	$0.00	$0.00	$0.00	$0.00	$70.15	$93.78	$79.57	$28.27	$0.00	$32.59	$99.90	$114.81	$75.54	$70.46	$90.55	$58.30
45																
46																
47	$0.00	$0.00	$0.00	$0.00	$386.02	$348.11	$571.23	$506.32	$0.00	$571.69	$367.07	$335.76	$437.07	$400.25	$468.72	$516.20
48	6,300	0	0	0	25,200	23,940	31,500	201,600	6,300	63,000	44,100	12,600	27,720	7,560	5,040	10,080
49																
50																
51																
52																
53																
54	86545CT1310041	86545CT1310024	86545CT1310020	86545CT1310018	86545CT1330002	86545CT1330009	86545CT1330004	86545CT1330001	86545CT1330010	86545CT1330003	86545CT1340005	86545CT1340010	86545CT1340006	86545CT1340011	86545CT1340012	86545CT1340013
55	$0.00	$372.61	$382.48	$357.60	$343.11	$330.78	$473.76	$472.94	$0.00	$550.91	$312.58	$0.00	$444.14	$0.00	$0.00	$0.00
56	0	3,627	9,139	10,917	24,120	21,402	40,952	167,014	0	66,087	53,697	0	12,129	0	0	0
57	$0	$1,351,460	$3,495,502	$3,903,927	$8,275,840	$7,079,418	$19,401,617	$78,986,963	$0	$36,407,705	$16,784,831	$0	$5,386,949	$0	$0	$0
58	100.00%	100.00%	100.00%	100.00%	99.67%	99.66%	99.76%	99.76%	100.00%	99.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
59	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
60	0.00%	0.00%	0.00%	0.00%	0.33%	0.34%	0.24%	0.24%	0.00%	0.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
61	$0	$1,179,332	$2,854,270	$4,176,196	$6,825,717	$5,904,895	$25,921,008	$101,719,401	$0	$68,118,609	$19,474,429	$0	$6,982,389	$0	$0	$0
62	100.00%	100.00%	100.00%	99.99%	99.99%	100.00%	99.94%	99.99%	100.00%	100.00%	100.00%	100.00%	99.78%	100.00%	100.00%	100.00%
63	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
64	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	0.06%	0.01%	0.00%	0.00%	0.00%	0.00%	0.22%	0.00%	0.00%	0.00%
65	$0	$68,855	$491,777	$907,608	-$168,180	-$110,643	$10,912,666	$40,764,435	$0	$35,440,071	$2,084,078	$0	$2,994,471	$0	$0	$0
66	$0	$0	$0	$0	$879	$855	$1,166,933	$6,738,895	$0	$527	$0	$0	$0	$0	$0	$0
67	#DIV/0!	0.00%	0.00%	0.00%	-0.52%	-0.77%	10.69%	16.53%	#DIV/0!	0.00%	0.00%	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	#DIV/0!
68	$0	$1,110,477	$2,362,493	$3,268,587	$6,993,897	$6,015,538	$15,008,342	$60,954,965	$0	$32,678,538	$17,390,350	$0	$3,987,918	$0	$0	$0
69																
70	$0.00	$110,600.87	$163,626.85	$536,997.68	$468,530.74	$570,239.56	$2,778,989.52	$9,537,940.41	$0.00	$8,233,458.98	$1,476,283.35	$0.00	$456,711.22	$0.00	$0.00	$0.00
71	$0.00	-$462,568.55	-$770,815.64	-$990,681.94	-$3,149,073.23	-$2,963,252.41	$3,056,019.64	$11,514,358.57	$0.00	$19,959,283.22	-$7,350,362.01	$0.00	$441,001.39	$0.00	$0.00	$0.00
72																
73	#DIV/0!	$306.17	$258.51	$299.40	$289.96	$281.07	$366.49	$364.97	#DIV/0!	$494.48	$323.86	#DIV/0!	$328.79	#DIV/0!	#DIV/0!	#DIV/0!
74	#DIV/0!	$325.15	$312.32	$382.54	$282.99	$275.90	$632.96	$609.05	#DIV/0!	$1,030.74	$362.67	#DIV/0!	$575.68	#DIV/0!	#DIV/0!	#DIV/0!
75	#DIV/0!	$325.15	$312.32	$382.49	$282.96	$275.89	$632.61	$608.96	#DIV/0!	$1,030.70	$362.66	#DIV/0!	$574.38	#DIV/0!	#DIV/0!	#DIV/0!
76																
77																
78																
79																
80	86545CT1310041	86545CT1310024	86545CT1310020	86545CT1310018	86545CT1330002	86545CT1330009	86545CT1330004	86545CT1330001	86545CT1330010	86545CT1330003	86545CT1340005	86545CT1340010	86545CT1340006	86545CT1340011	86545CT1340012	86545CT1340013
81	$745.24	$0.00	$0.00	$0.00	$433.82	$442.06	$592.19	$591.05	$591.27	$789.98	$470.60	$446.49	$568.70	$557.58	$683.17	$786.06
82	6,300	-	-	-	25,200	23,940	31,500	201,600	6,300	63,000	44,100	12,600	27,720	7,560	5,040	10,080
83	$4,695,028	$0	$0	$0	$10,932,371	$10,582,996	$18,653,917	$119,155,599	$3,725,016	$49,768,724	$20,753,392	$5,625,823	$15,764,269	$4,215,306	$3,443,170	$7,923,508
84	99.86%	0.00%	0.00%	0.00%	99.76%	99.76%	99.82%	99.82%	99.48%	99.86%	99.78%	99.77%	99.81%	99.81%	99.84%	99.86%
85	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
86	0.14%	100.00%	100.00%	100.00%	0.24%	0.24%	0.18%	0.18%	0.52%	0.14%	0.22%	0.23%	0.19%	0.19%	0.16%	0.14%
87	$4,848,856	$0	$0	$0	$15,501,879	$15,051,234	$22,679,773	$126,405,601	$4,885,306	$49,305,032	$29,236,162	$8,254,530	$19,681,960	$5,241,261	$4,048,854	$8,202,603
88	99.86%	0.00%	0.00%	0.00%	99.76%	99.76%	99.82%	99.82%	99.48%	99.86%	99.78%	99.77%	99.81%	99.81%	99.84%	99.86%
89	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
90	0.14%	100.00%	100.00%	100.00%	0.24%	0.24%	0.18%	0.18%	0.52%	0.14%	0.22%	0.23%	0.19%	0.19%	0.16%	0.14%
91	$988,569	$0	$0	$0	$6,370,353	$6,211,441	$7,093,121	$26,842,342	$1,778,041	$7,709,334	$12,180,354	$3,631,446	$6,723,601	$1,776,306	$1,218,074	$1,687,591
92	$0	$0	$0	$0	$0	$0	$1,841,221	$11,761,166	$367,675	$0	$0	$0	$0	$0	$0	$0
93	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	0.00%	25.96%	43.82%	20.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
94	$3,860,287	$0	$0	$0	$9,131,526	$8,839,793	$15,586,652	$99,563,259	$3,107,265	$41,595,698	$17,055,808	$4,623,084	$12,958,359	$3,464,955	$2,830,781	$6,515,012
95																
96	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
97	$250,106	$0	$0	$0	$591,628	$572,726	$1,009,853	$6,450,661	$201,318	$2,694,968	$1,105,039	$299,528	$839,567	$224,493	$183,405	$422,105
98																
99	$612.74	#DIV/0!	#DIV/0!	#DIV/0!	$362.36	$369.25	$494.81	$493.87	$493.22	$660.25	$386.75	$366.91	$467.47	$458.33	$561.66	$646.33
100	$769.66	#DIV/0!	#DIV/0!	#DIV/0!	$615.15	$628.71	$719.99	$627.01	$775.45	$782.62	$662.95	$655.12	$710.03	$693.29	$803.34	$813.75
101	$768.58	#DIV/0!	#DIV/0!	#DIV/0!	$613.68	$627.20	$718.70	$625.88	$771.41	$781.52	$661.49	$653.61	$708.68	$691.97	$802.06	$812.61

	AG	AH	AI	AJ
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12			HMO MSP	PPO MSP
13			86545CT147	86545CT148
14	Silver	Silver	Gold	Silver
15	0.691	0.688	0.800	0.712
16	0.010	0.010	0.976	0.921
17	Terminated	Terminated	Renewing	Renewing
18	HMO	PPO	HMO	PPO
19	Anthem HMO BlueCare 3500/0%	Anthem PPO Century Preferred 2500/20%	Pathway X Enhanced, a Multi-State Plan	Silver PPO Pathway X, a Multi-State Plan
20	86545CT1340008	86545CT1340007	86545CT1470002	86545CT1480002
21	No	No	Yes	Yes
22			0.00%	0.00%
23			-2.26%	2.86%
24			27.29%	21.50%
25	1/1/2017	1/1/2017	1/1/2017	1/1/2017
26	0.00%	0.00%	27.29%	21.51%
27	0.00%	0.00%	27.29%	21.51%
28	-100.00%	-100.00%	24.94%	25.09%
29			27.29%	21.50%
30				
31				
32				
33	86545CT1340008	86545CT1340007	86545CT1470002	86545CT1480002
34	$0.00	$0.00	$30.85	$27.45
35	$0.00	$0.00	$44.59	$39.68
36	$0.00	$0.00	$39.84	$35.45
37	$0.00	$0.00	$34.88	$31.04
38	$0.00	$0.00	$3.55	$3.16
39	$0.00	$0.00	$0.00	$0.00
40	$0.00	$0.00	-$12.64	-$12.27
41	$0.00	$0.00	-$13.61	-$11.18
42	$0.00	$0.00	$0.00	$0.00
43	$0.00	$0.00	$127.46	$113.33
44	$0.00	$0.00	$53.55	$79.62
45				
46				
47	$0.00	$0.00	$467.00	$526.88
48	0	0	5,040	13,860
49				
50				
51				
52				
53				
54	86545CT1340008	86545CT1340007	86545CT1470002	86545CT1480002
55	$450.93	$455.00	$502.21	$473.21
56	14,782	7,785	4,907	11,939
57	$6,665,591	$3,542,211	$2,464,337	$5,649,609
58	100.00%	100.00%	100.00%	99.87%
59	0.00%	0.00%	0.00%	0.00%
60	0.00%	0.00%	0.00%	0.13%
61	$5,193,861	$5,277,879	$3,988,111	$7,789,195
62	99.99%	99.98%	99.98%	99.99%
63	0.00%	0.00%	0.00%	0.00%
64	0.01%	0.02%	0.02%	0.01%
65	$240,240	$2,617,637	$2,255,621	$2,903,217
66	$0	$0	$0	$410,319
67	0.00%	0.00%	0.00%	14.13%
68	$4,953,620	$2,660,242	$1,732,490	$4,885,978
69				
70	$325,123.28	$300,324.14	$450,494.91	$681,803.92
71	-$1,596,675.53	$772,708.22	$1,294,369.57	$634,917.41
72				
73	$335.11	$341.71	$353.07	$409.25
74	$351.36	$677.95	$812.74	$652.42
75	$351.35	$677.83	$812.61	$652.38
76				
77				
78				
79				
80	86545CT1340008	86545CT1340007	86545CT1470002	86545CT1480002
81	$0.00	$0.00	$627.44	$591.93
82	-	-	5,040	13,860
83	$0	$0	$3,162,273	$8,204,097
84	0.00%	0.00%	99.99%	99.99%
85	0.00%	0.00%	0.00%	0.00%
86	100.00%	100.00%	0.01%	0.01%
87	$0	$0	$3,502,927	$9,974,686
88	0.00%	0.00%	99.99%	99.99%
89	0.00%	0.00%	0.00%	0.00%
90	100.00%	100.00%	0.01%	0.01%
91	$0	$0	$860,477	$3,119,593
92	$0	$0	$0	$809,779
93	#DIV/0!	#DIV/0!	0.00%	25.96%
94	$0	$0	$2,642,450	$6,855,094
95				
96	$0	$0	$0	$0
97	$0	$0	$171,203	$444,139
98				
99	#DIV/0!	#DIV/0!	$524.30	$494.60
100	#DIV/0!	#DIV/0!	$695.03	$719.67
101	#DIV/0!	#DIV/0!	$694.96	$719.60

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT133

Applicable HIOS Plan IDs (Standard Component):

86545CT1330010-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

1 Benefit designs have member cost shares that differ by site of service for Outpatient Mental/Behavioral Health and Substance Use Disorders (MH), specifically outpatient MH office visits versus other outpatient MH facility and professional visits. The AV calculator does not have the functionality to vary cost shares by site of service.

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the member cost shares for outpatient professional mental health office visits and the member cost shares for outpatient mental health facility and professional other visits is calculated and converted to an effective coinsurance.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

1 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These benefit designs have been tested and meet the regulatory requirements. Using proprietary claims data, from a nationally known consulting firm, frequency weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital or facility setting to calculate an effective coinsurance.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments: This method was not used.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Michele L. Archer, FSA, MAAA

Date: May 12, 2016

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT123

Applicable HIOS Plan IDs (Standard Component):
86545CT1230002-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

1 Benefit designs include one or more of the following benefit features that are not supported by the functionality of the AV calculator:
A. Flat dollar copayment for Outpatient Facility Fee
B. Flat dollar copayment for Outpatient Surgery Physician/Surgical Services
C. Flat dollar copayment and percentage coinsurance for the same medical or Rx benefit category

2 Benefit designs have member cost shares that differ by site of service for Outpatient Mental/Behavioral Health and Substance Use Disorders (MH), specifically outpatient MH office visits versus other outpatient MH facility and professional visits. The AV calculator does not have the functionality to vary cost shares by site of service.

3 Benefit designs apply a member copay prior to deductible for a limited number of office visits with remaining office visits subject to deductible and coinsurance. The limited visits at a copayment are combined across multiple benefit categories. In addition to Primary Care Visit, limits apply across Specialist Visit, Outpatient Mental/Behavioral Health and Substance Use Disorder Office Services, Rehabilitative Speech Therapy, and/or Rehabilitative Physical and Occupational Therapies. The limited copays prior to deductible functionality in the AV calculator is only applicable to the Primary Care Visit benefit category.

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), the actual cost shares are converted into plan effective coinsurance percentages.

2 Per 156.135(b)(2), a weighted average of the member cost shares for outpatient professional mental health office visits and the member cost shares for outpatient mental health facility and professional other visits is calculated and converted to an effective coinsurance.

3 Per 156.135(b)(2), a weighted average of the member cost shares for visits subject to copays and the member cost shares for visits subject to plan deductible and coinsurance is calculated and converted to an effective coinsurance.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

1 For Outpatient Facility Fee, used the average cost and frequency data from a nationally recognized consulting firm trended to 2017. For all other benefit categories, used the cost and frequency data from the AV calculator continuance tables at the appropriate charge level associated with the OOP limit. Used linear interpolation when the exact level was not available in the continuance table. The charge level associated with the OOP was considered "unlimited" when the plan overall (medical or Rx, as applicable) coinsurance was 100%. When the plan overall coinsurance was less than 100%, the following formula was used to calculate the charge level associated with the OOP.

$$\text{Stop Loss} = \frac{\text{(OOP Max - Deductible)}}{\text{1 - Plan Coinsurance}} + \text{Deductible}$$

where Stop Loss = charge level associated with OOP

The effective coinsurance was calculated using the following formula:

$$\text{Plan Eff Coins} = \text{Min}\left(1, \text{Max}\left(0, \frac{\text{(Ben Cost - Ben Copay • Ben Freq) x (1-Ben Coins)}}{\text{Ben Cost}}\right)\right)$$

where:
Ben Cost = average benefit cost PMPY
Ben Freq = average benefit frequency PMPY
Ben Copay = member copayment for the benefit category
Ben Coins = member coinsurance for the benefit category

2 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These benefit designs have been tested and meet the regulatory requirements. Using proprietary claims data, from a nationally known consulting firm, frequency weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital or facility setting to calculate an effective coinsurance.

3 Using proprietary claims data, weightings were determined to model the number of office visit services that would be subject to a limited copayment or the plan deductible and coinsurance. Due to the combined structure of the office visit services, across several categories, a redistribution of the weighting factors were modeled based on frequency of service statistics from a nationally known consulting firm. The final weightings were used to convert the plan member cost shares to an effective coinsurance for each service category subject to the limited visits at a copayment.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments: This method was not used.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Michele L. Archer, FSA, MAAA

Date: May 12, 2016

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT123

Applicable HIOS Plan IDs (Standard Component):
86545CT1230004-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

1 Benefit designs include one or more of the following benefit features that are not supported by the functionality of the AV calculator:
A. Flat dollar copayment for Outpatient Facility Fee
B. Flat dollar copayment for Outpatient Surgery Physician/Surgical Services
C. Flat dollar copayment and percentage coinsurance for the same medical or Rx benefit category

2 Benefit designs have member cost shares that differ by site of service for Outpatient Mental/Behavioral Health and Substance Use Disorders (MH), specifically outpatient MH office visits versus other outpatient MH facility and professional visits. The AV calculator does not have the functionality to vary cost shares by site of service.

3 Benefit designs have a member coinsurance payment on 1 or more of the Drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator (AVC) is limited to a maximum on Specialty Drugs (i.e. high-cost) coinsurance. The impacted Rx member cost shares fall into 1 of the following categories:
1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), the actual cost shares are converted into plan effective coinsurance percentages.

2 Per 156.135(b)(2), a weighted average of the member cost shares for outpatient professional mental health office visits and the member cost shares for outpatient mental health facility and professional other visits is calculated and converted to an effective coinsurance.

3 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

1 For Outpatient Facility Fee, used the average cost and frequency data from a nationally recognized consulting firm trended to 2017. For all other benefit categories, used the cost and frequency data from the AV calculator continuance tables at the appropriate charge level associated with the OOP limit. Used linear interpolation when the exact level was not available in the continuance table. The charge level associated with the OOP was considered "unlimited" when the plan overall (medical or Rx, as applicable) coinsurance was 100%. When the plan overall coinsurance was less than 100%, the following formula was used to calculate the charge level associated with the OOP.

$$\text{Stop Loss} = \frac{\text{(OOP Max - Deductible)}}{\text{1 - Plan Coinsurance}} + \text{Deductible}$$

where Stop Loss = charge level associated with OOP

The effective coinsurance was calculated using the following formula:

$$\text{Plan Eff Coins} = \text{Min}\left(1, \text{Max}\left(0, \frac{\text{(Ben Cost - Ben Copay} \bullet \text{Ben Freq) x (1-Ben Coins)}}{\text{Ben Cost}}\right)\right)$$

where:
Ben Cost = average benefit cost PMPY
Ben Freq = average benefit frequency PMPY
Ben Copay = member copayment for the benefit category
Ben Coins = member coinsurance for the benefit category

2 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These benefit designs have been tested and meet the regulatory requirements. Using proprietary claims data, from a nationally known consulting firm, frequency weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital or facility setting to calculate an effective coinsurance.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

3 Data used: In addition to the AVC continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AV Calculator (AVC). We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Michele L. Archer, FSA, MAAA

Date: May 12, 2016

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT147

Applicable HIOS Plan IDs (Standard Component):

86545CT1470002-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

1 Benefit designs have member cost shares that differ by site of service for Outpatient Mental/Behavioral Health and Substance Use Disorders (MH), specifically outpatient MH office visits versus other outpatient MH facility and professional visits. The AV calculator does not have the functionality to vary cost shares by site of service.

2 Benefit designs have a member coinsurance payment on 1 or more of the Drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator (AVC) is limited to a maximum on Specialty Drugs (i.e. high-cost) coinsurance. The impacted Rx member cost shares fall into 1 of the following categories:
1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the member cost shares for outpatient professional mental health office visits and the member cost shares for outpatient mental health facility and professional other visits is calculated and converted to an effective coinsurance.

2 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

1 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These benefit designs have been tested and meet the regulatory requirements. Using proprietary claims data, from a nationally known consulting firm, frequency weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital or facility setting to calculate an effective coinsurance.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

2 Data used: In addition to the AVC continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AV Calculator (AVC). We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Michele L. Archer, FSA, MAAA

Date: May 12, 2016

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT133, 86545CT148

Applicable HIOS Plan IDs (Standard Component):
86545CT1330004-01, 86545CT1480002-01

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

1 Benefit designs have member cost shares that differ by site of service for Outpatient Mental/Behavioral Health and Substance Use Disorders (MH), specifically outpatient MH office visits versus other outpatient MH facility and professional visits. The AV calculator does not have the functionality to vary cost shares by site of service.

2 Benefit designs apply a member copay prior to deductible for a limited number of office visits with remaining office visits subject to deductible and coinsurance. The limited visits at a copayment are combined across multiple benefit categories. In addition to Primary Care Visit, limits apply across Specialist Visit, Outpatient Mental/Behavioral Health and Substance Use Disorder Office Services, Rehabilitative Speech Therapy, and/or Rehabilitative Physical and Occupational Therapies. The limited copays prior to deductible functionality in the AV calculator is only applicable to the Primary Care Visit benefit category.

3 Benefit designs have a member coinsurance payment on 1 or more of the Drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator (AVC) is limited to a maximum on Specialty Drugs (i.e. high-cost) coinsurance. The impacted Rx member cost shares fall into 1 of the following categories:
1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the member cost shares for outpatient professional mental health office visits and the member cost shares for outpatient mental health facility and professional other visits is calculated and converted to an effective coinsurance.

2 Per 156.135(b)(2), a weighted average of the member cost shares for visits subject to copays and the member cost shares for visits subject to plan deductible and coinsurance is calculated and converted to an effective coinsurance.

3 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

1 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These benefit designs have been tested and meet the regulatory requirements. Using proprietary claims data, from a nationally known consulting firm, frequency weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital or facility setting to calculate an effective coinsurance.

2 Using proprietary claims data, weightings were determined to model the number of office visit services that would be subject to a limited copayment or the plan deductible and coinsurance. Due to the combined structure of the office visit services, across several categories, a redistribution of the weighting factors were modeled based on frequency of service statistics from a nationally known consulting firm. The final weightings were used to convert the plan member cost shares to an effective coinsurance for each service category subject to the limited visits at a copayment.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

3 Data used: In addition to the AVC continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AV Calculator (AVC). We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Michele L. Archer, FSA, MAAA

Date: May 12, 2016

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT131, 86545CT134

Applicable HIOS Plan IDs (Standard Component):
86545CT1310032-00, 86545CT1310031-00, 86545CT1310041-00, 86545CT1310042-00, 86545CT1340013-00

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

1 Benefit designs include one or more of the following benefit features that are not supported by the functionality of the AV calculator:
A. Flat dollar copayment for Outpatient Facility Fee
B. Flat dollar copayment for Outpatient Surgery Physician/Surgical Services
C. Flat dollar copayment and percentage coinsurance for the same medical or Rx benefit category

2 Benefit designs have member cost shares that differ by site of service for Outpatient Mental/Behavioral Health and Substance Use Disorders (MH), specifically outpatient MH office visits versus other outpatient MH facility and professional visits. The AV calculator does not have the functionality to vary cost shares by site of service.

3 Benefit designs have a member coinsurance payment on 1 or more of the Drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator (AVC) is limited to a maximum on Specialty Drugs (i.e. high-cost) coinsurance. The impacted Rx member cost shares fall into 1 of the following categories:
1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), the actual cost shares are converted into plan effective coinsurance percentages.

2 Per 156.135(b)(2), a weighted average of the member cost shares for outpatient professional mental health office visits and the member cost shares for outpatient mental health facility and professional other visits is calculated and converted to an effective coinsurance.

3 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

1 For Outpatient Facility Fee, used the average cost and frequency data from a nationally recognized consulting firm trended to 2017. For all other benefit categories, used the cost and frequency data from the AV calculator continuance tables at the appropriate charge level associated with the OOP limit. Used linear interpolation when the exact level was not available in the continuance table. The charge level associated with the OOP was considered "unlimited" when the plan overall (medical or Rx, as applicable) coinsurance was 100%. When the plan overall coinsurance was less than 100%, the following formula was used to calculate the charge level associated with the OOP.

$$\text{Stop Loss} = \frac{\text{(OOP Max - Deductible)}}{\text{1 - Plan Coinsurance}} + \text{Deductible}$$

where Stop Loss = charge level associated with OOP

The effective coinsurance was calculated using the following formula:

$$\text{Plan Eff Coins} = \text{Min}\left(1, \text{Max}\left(0, \frac{\text{(Ben Cost - Ben Copay • Ben Freq) x (1-Ben Coins)}}{\text{Ben Cost}}\right)\right)$$

where:
Ben Cost = average benefit cost PMPY
Ben Freq = average benefit frequency PMPY
Ben Copay = member copayment for the benefit category
Ben Coins = member coinsurance for the benefit category

2 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These benefit designs have been tested and meet the regulatory requirements. Using proprietary claims data, from a nationally known consulting firm, frequency weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital or facility setting to calculate an effective coinsurance.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

3 Data used: In addition to the AVC continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AV Calculator (AVC). We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Michele L. Archer, FSA, MAAA

Date: May 12, 2016

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT134

Applicable HIOS Plan IDs (Standard Component):
86545CT1340012-00, 86545CT1340011-00

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

1 Benefit designs have a member coinsurance payment on 1 or more of the Drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator (AVC) is limited to a maximum on Specialty Drugs (i.e. high-cost) coinsurance. The impacted Rx member cost shares fall into 1 of the following categories:
1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator: This method was not used.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

1 Data used: In addition to the AVC continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AV Calculator (AVC). We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Michele L. Archer, FSA, MAAA

Date: May 12, 2016

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 86545

HIOS Product IDs: 86545CT134

Applicable HIOS Plan IDs (Standard Component):

86545CT1340006-00

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

1 Benefit designs have member cost shares that differ by site of service for Outpatient Mental/Behavioral Health and Substance Use Disorders (MH), specifically outpatient MH office visits versus other outpatient MH facility and professional visits. The AV calculator does not have the functionality to vary cost shares by site of service.

2 Benefit designs have a member coinsurance payment on 1 or more of the Drugs benefit categories that is either floored or capped at a set amount per script. This functionality in the AV Calculator (AVC) is limited to a maximum on Specialty Drugs (i.e. high-cost) coinsurance. The impacted Rx member cost shares fall into 1 of the following categories:
1. Greater of copay or coinsurance percentage
2. Coinsurance with maximum copay per script
3. Coinsurance with minimum and maximum copays per script

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

1 Per 156.135(b)(2), a weighted average of the member cost shares for outpatient professional mental health office visits and the member cost shares for outpatient mental health facility and professional other visits is calculated and converted to an effective coinsurance.

2 Per 156.135(b)(3), the actual Rx cost shares are converted into plan effective coinsurance percentages.

Confirmation that only in-network cost sharing, including multitier networks, was considered: Yes

Description of the standardized plan population data used: Used AV Calculator population data.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

1 The Interim Final Rule 45 CFR Part 146 under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHP) and EHB guidance allows separation of cost share types between outpatient other and office visits as allowed under the MHPAEA July 1, 2010 Enforcement Safe Harbor guidance. The Final Rule released on November 13, 2013 retained the sub-classification provision. These benefit designs have been tested and meet the regulatory requirements. Using proprietary claims data, from a nationally known consulting firm, frequency weightings were calculated and applied to the member cost shares for MH/SA services in an office based setting and in a hospital or facility setting to calculate an effective coinsurance.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

2 Data used: In addition to the AVC continuance tables, we used Rx cost and utilization data from a nationally recognized consulting firm.
Method Used: We calculated an effective coinsurance for each impacted Rx benefit category outside the AV Calculator (AVC). We input our calculated effective coinsurance(s) into the AVC.
Description: It is common for the allowed cost of a drug to be less than an Rx copay, therefore, we used proprietary Rx data from a nationally known consulting firm to calculate the effective copay for each of the impacted Rx tiers and then converted the effective copay into an effective coinsurance. The Rx claims data was calibrated at each charge level bucket and cost per script for each Rx tier, based on the AVC average allowed cost per script. The AVC average allowed cost per script was determined by taking the plan charge level Rx average cost PMPY and dividing by the corresponding Rx average scripts PMPY.
Greater of copay or coinsurance: For each calibrated cost per script bucket, the member cost share with only the copay was calculated and the member cost share with only the coinsurance was calculated. The maximum of the two was the final member cost share, expressed as a copay. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.
Coinsurance with minimum and/or maximum copay per script: For each calibrated cost per script bucket, the member cost share with only the coinsurance was calculated, expressed as a copay. The member cost share in each cost per script bucket was replaced with either the minimum copay per script or the maximum copay per script when applicable. The weighted average member copay and the weighted average allowed cost per script were both calculated using the distribution of scripts by cost per script bucket. The effective coinsurance was calculated by dividing the weighted average member copay by the weighted average allowed cost per script and input into the AVC.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Michele L. Archer, FSA, MAAA

Date: May 12, 2016

WAKELY CONSULTING GROUP

Individual Market Gold Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,550.00	$25.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	80.00%				
OOP Maximum ($)	$3,500.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☐	☐		$150.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$53.60	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$65.00	☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$20.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$20.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$40.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	81%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑	81%		☑	☑				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$25.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$50.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☑
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	$100
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: 2017 Individual Market Standard Gold
Plan HIOS ID: 86545CT1330003
Issuer HIOS ID: 86545

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.05%
Metal Tier:	Gold

2017 AV Calculator

WAKELY CONSULTING GROUP

Individual Market Silver Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$4,000.00	$150.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	80.00%				
OOP Maximum ($)	$7,150.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☐	☐		$200.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$50.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$72.20	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$40.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	81%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑	81%		☑	☑				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☑
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	$200
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: 2017 Individual Market Standard Silver
Plan HIOS ID: 86545CT1330001
Issuer HIOS ID: 86545

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.98%
Metal Tier:	Silver

2017 AV Calculator

WAKELY CONSULTING GROUP

Individual Market Silver Plan – 73% AV Cost Sharing Reduction

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,400.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	80.00%				
OOP Maximum ($)	$5,700.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☐	☐		$200.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$50.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$72.20	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00	☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$40.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	81%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑	81%		☑	☑				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☑
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	$100
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: 2017 Individual Market Standard Silver 73% CSR
Plan HIOS ID: 86545CT1330001
Issuer HIOS ID: 86545

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.98%
Metal Tier:	Silver

2017 AV Calculator

WAKELY CONSULTING GROUP

Individual Market Silver Plan – 87% AV Cost Sharing Reduction

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$700.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	80.00%				
OOP Maximum ($)	$1,800.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☐	☐		$75.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$100.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$35.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.60	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$60.00	☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$20.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$20.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$100.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑	96%		☑	☑				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$20.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☑	
Set a Maximum on Specialty Rx Coinsurance Payments?		
Specialty Rx Coinsurance Maximum:		$60
Set a Maximum Number of Days for Charging an IP Copay?	☑	
# Days (1-10):		4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

Name: 2017 Individual Market Standard Silver 87% CSR
Plan HIOS ID: 86545CT1330001
Issuer HIOS ID: 86545

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.87%
Metal Tier:	Gold

2017 AV Calculator

WAKELY CONSULTING GROUP

Individual Market Silver Plan – 94% AV Cost Sharing Reduction

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	80.00%				
OOP Maximum ($)	$1,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☐	☐		$50.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$75.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$30.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$12.40	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$50.00	☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$20.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$20.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$25.00	☑	☑			☐	☐
Skilled Nursing Facility	☐	☐		$50.00	☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	98%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☐	☑	98%		☑	☑				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$10.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$30.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☑
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	$60
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	4
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: 2017 Individual Market Standard Silver 94% CSR
Plan HIOS ID: 86545CT1330001
Issuer HIOS ID: 86545CT

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.97%
Metal Tier:	Platinum

2017 AV Calculator

WAKELY CONSULTING GROUP

Individual Market Bronze Non-HSA Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$76.80	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$10.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	81%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑	81%		☑	☑				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☑	☐		$5.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☑	50%		☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☑	
Set a Maximum on Specialty Rx Coinsurance Payments?		
Specialty Rx Coinsurance Maximum:		$500
Set a Maximum Number of Days for Charging an IP Copay?	☑	
# Days (1-10):		2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

Name: 2017 Individual & SHOP Markets Standard Bronze Non-HSA
Plan HIOS ID: 86545CT1330002
Issuer HIOS ID: 86545

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.98%
Metal Tier:	Bronze

2017 AV Calculator

Individual Market Bronze HSA Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$5,685.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,550.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($)			
OOP Maximum if Separate ($)			

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑	85%		☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	75%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☑
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: 2017 Individual Market Standard Bronze HSA
Plan HIOS ID: 86545CT1330009
Issuer HIOS ID: 86545

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	62.00%
Metal Tier:	Bronze

2017 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,800.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

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	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	78%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	71%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT123
HIOS Plan ID: 86545CT1230002-01

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.98%
Metal Tier:	Bronze

2017 AV Calculator

	$3,684.25
	$5,943.92

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,250.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,550.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$150.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$200.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$200.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT123
HIOS Plan ID: 86545CT1230001-01

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.91%
Metal Tier:	Bronze

2017 AV Calculator

	$3,680.02
	$5,943.92

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,800.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$50.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	55%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	62%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑	
Specialty Rx Coinsurance Maximum:		$500
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT123
HIOS Plan ID: 86545CT1230004-01

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.84%
Metal Tier:	Gold

2017 AV Calculator

	$5,226.08
	$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,850.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$50.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	81%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	62%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑	
Specialty Rx Coinsurance Maximum:		$500
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT147
HIOS Plan ID: 86545CT1470002-01

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.98%
Metal Tier:	Gold

2017 AV Calculator

	$5,170.25
	$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,300.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$6,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☐			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	75%		☐	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☐			☐	☐
Rehabilitative Speech Therapy	☑	☑			☐	☐			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$40.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330010-01

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.80%
Metal Tier:	Silver

2017 AV Calculator

	$4,249.08
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$5,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☐			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	74%		☐	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☐			☐	☐
Rehabilitative Speech Therapy	☑	☑			☐	☐			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$40.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330010-04

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.02%
Metal Tier:	Silver

2017 AV Calculator

	$4,448.42
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$1,850.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☐			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	77%		☐	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☐			☐	☐
Rehabilitative Speech Therapy	☑	☑			☐	☐			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$40.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330010-05

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.01%
Metal Tier:	Gold

2017 AV Calculator

	$5,560.42
	$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$250.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☐			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	81%		☐	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☐			☐	☐
Rehabilitative Speech Therapy	☑	☑			☐	☐			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$25.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330010-06

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.03%
Metal Tier:	Platinum

2017 AV Calculator

	$6,465.36
	$6,949.49

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	77%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑	
Specialty Rx Coinsurance Maximum:		$500
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330004-01

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.21%
Metal Tier:	Silver

2017 AV Calculator

	$4,398.29
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,900.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	83%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	92%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$55.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑	
Specialty Rx Coinsurance Maximum:		$500
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330004-04

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.85%
Metal Tier:	Silver

2017 AV Calculator

	$4,560.98
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$100.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	89%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	95%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$250.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330004-05

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.78%
Metal Tier:	Gold

2017 AV Calculator

	$5,674.91
	$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$75.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$150.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	92%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	96%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$150.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT133
HIOS Plan ID: 86545CT1330004-06

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.57%
Metal Tier:	Platinum

2017 AV Calculator

	$6,571.98
	$6,949.49

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	77%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑	
Specialty Rx Coinsurance Maximum:		$500
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT148
HIOS Plan ID: 86545CT1480002-01

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.21%
Metal Tier:	Silver

2017 AV Calculator

	$4,398.29
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,900.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,500.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	83%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	92%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$55.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	66%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑	
Specialty Rx Coinsurance Maximum:		$500
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT148
HIOS Plan ID: 86545CT1480002-04

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.91%
Metal Tier:	Silver

2017 AV Calculator

	$4,565.02
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$100.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	89%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	95%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$250.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT148
HIOS Plan ID: 86545CT1480002-05

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.78%
Metal Tier:	Gold

2017 AV Calculator

	$5,674.91
	$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$75.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$150.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	92%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	96%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$150.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$35.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT148
HIOS Plan ID: 86545CT1480002-06

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.57%
Metal Tier:	Platinum

2017 AV Calculator

	$6,571.98
	$6,949.49

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,200.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,550.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$350.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310019-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.96%
Metal Tier:	Bronze

2017 AV Calculator

	$3,682.59
	$5,943.92

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,800.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$50.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	55%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	62%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310032-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.84%
Metal Tier:	Gold

2017 AV Calculator

	$5,226.08
	$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,850.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

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	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$50.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	55%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310031-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.98%
Metal Tier:	Silver

2017 AV Calculator

	$4,446.00
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,000.00			
OOP Maximum if Separate ($)						

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	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310030-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.71%
Metal Tier:	Silver

2017 AV Calculator

	$4,429.16
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	70%
		2nd Tier Utilization:	30%

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$1,650.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$6,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		$3,300.00
		100.00%
		$6,000.00

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	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☐		$200.00	☑	☑
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☐		$400.00	☑	☑
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☐	☐		$35.00	☐	☐
Specialist Visit	☐	☐		$45.00	☐	☐		$45.00	☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	72%		☐	☑	66%		☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☐		$75.00	☑	☑
Rehabilitative Speech Therapy	☐	☐		$20.00	☐	☐		$20.00	☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$20.00	☐	☐		$20.00	☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☐	☐		$10.00	☐	☐
X-rays and Diagnostic Imaging	☐	☑	94%		☐	☑	94%		☐	☐
Skilled Nursing Facility	☑	☐		$250.00	☑	☐		$400.00	☑	☑
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	94%		☑	☑	94%			
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐		$5.00	☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☐	☐		$60.00	☐	☐
Non-Preferred Brand Drugs	☑	☑	67%		☑	☑	67%		☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑	60%		☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310041-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.07%
Metal Tier:	Gold

2017 AV Calculator

$5,111.84
$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	80%
		2nd Tier Utilization:	20%

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$3,550.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$7,150.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		$6,400.00
		100.00%
		$7,150.00

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☑	☐		$200.00	☑	☑
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$400.00	☑	☐		$500.00	☑	☑
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		$40.00	☐	☐
Specialist Visit	☐	☐		$50.00	☐	☐		$50.00	☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	61%		☐	☑	55%		☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☐		$75.00	☑	☑
Rehabilitative Speech Therapy	☐	☐		$30.00	☐	☐		$30.00	☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☐	☐		$30.00	☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$10.00	☑	☐		$10.00	☑	☑
X-rays and Diagnostic Imaging	☑	☑	93%		☑	☑	93%		☐	☐
Skilled Nursing Facility	☑	☐		$400.00	☑	☐		$500.00	☑	☑
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑	90%			
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☐	☐		$5.00	☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☐	☐		$60.00	☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑	60%		☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑	50%		☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT131
HIOS Plan ID: 86545CT1310042-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.98%
Metal Tier:	Silver

2017 AV Calculator

	$4,445.93
	$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,700.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,550.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT134
HIOS Plan ID: 86545CT1340005-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.61%
Metal Tier:	Bronze

2017 AV Calculator

	$3,662.25
	$5,943.92

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,150.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT134
HIOS Plan ID: 86545CT1340010-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.43%
Metal Tier:	Bronze

2017 AV Calculator

	$3,532.71
	$5,943.92

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$3,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑	50%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	50%		☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	50%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	59%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT134
HIOS Plan ID: 86545CT1340012-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.33%
Metal Tier:	Gold

2017 AV Calculator

	$5,063.73
	$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,900.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

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	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☐	☐		$150.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$50.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	61%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☑	93%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$30.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	62%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT134
HIOS Plan ID: 86545CT1340013-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.49%
Metal Tier:	Gold

2017 AV Calculator

	$5,203.74
	$6,464.79

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

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	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑	50%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☑	76%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	50%		☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	50%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$5.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$60.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	59%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT134
HIOS Plan ID: 86545CT1340006-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.48%
Metal Tier:	Silver

2017 AV Calculator

$4,414.77
$6,176.34

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
		$3,000.00			
		80.00%			
		$4,850.00			

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑	50%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	50%		☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	50%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	58%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

HIOS Issuer ID: 86545
HIOS Product ID: 86545CT134
HIOS Plan ID: 86545CT1340011-00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.77%
Metal Tier:	Silver

2017 AV Calculator

	$4,309.40
	$6,176.34

2017 Rates Table Template v6.0	*All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.*			
	If you are a community rating state, select Family Option under Age and fill in all columns.			
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.			
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.			
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.			
HIOS Issuer ID*	86545			
Federal TIN*	06-1475928			
Rate Effective Date*	1/1/2017			
Rate Expiration Date*	12/31/2017			

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
86545CT1230005	Rating Area 1	No Preference	0-20	139.73
86545CT1230005	Rating Area 1	No Preference	21	220.04
86545CT1230005	Rating Area 1	No Preference	22	220.04
86545CT1230005	Rating Area 1	No Preference	23	220.04
86545CT1230005	Rating Area 1	No Preference	24	220.04
86545CT1230005	Rating Area 1	No Preference	25	220.92
86545CT1230005	Rating Area 1	No Preference	26	225.32
86545CT1230005	Rating Area 1	No Preference	27	230.60
86545CT1230005	Rating Area 1	No Preference	28	239.18
86545CT1230005	Rating Area 1	No Preference	29	246.22
86545CT1230005	Rating Area 1	No Preference	30	249.75
86545CT1230005	Rating Area 1	No Preference	31	255.03
86545CT1230005	Rating Area 1	No Preference	32	260.31
86545CT1230005	Rating Area 1	No Preference	33	263.61
86545CT1230005	Rating Area 1	No Preference	34	267.13
86545CT1230005	Rating Area 1	No Preference	35	268.89
86545CT1230005	Rating Area 1	No Preference	36	270.65
86545CT1230005	Rating Area 1	No Preference	37	272.41
86545CT1230005	Rating Area 1	No Preference	38	274.17
86545CT1230005	Rating Area 1	No Preference	39	277.69
86545CT1230005	Rating Area 1	No Preference	40	281.21
86545CT1230005	Rating Area 1	No Preference	41	286.49
86545CT1230005	Rating Area 1	No Preference	42	291.55
86545CT1230005	Rating Area 1	No Preference	43	298.59
86545CT1230005	Rating Area 1	No Preference	44	307.40
86545CT1230005	Rating Area 1	No Preference	45	317.74
86545CT1230005	Rating Area 1	No Preference	46	330.06
86545CT1230005	Rating Area 1	No Preference	47	343.92
86545CT1230005	Rating Area 1	No Preference	48	359.77
86545CT1230005	Rating Area 1	No Preference	49	375.39
86545CT1230005	Rating Area 1	No Preference	50	392.99
86545CT1230005	Rating Area 1	No Preference	51	410.37
86545CT1230005	Rating Area 1	No Preference	52	429.52
86545CT1230005	Rating Area 1	No Preference	53	448.88
86545CT1230005	Rating Area 1	No Preference	54	469.79
86545CT1230005	Rating Area 1	No Preference	55	490.69
86545CT1230005	Rating Area 1	No Preference	56	513.35
86545CT1230005	Rating Area 1	No Preference	57	536.24
86545CT1230005	Rating Area 1	No Preference	58	560.66
86545CT1230005	Rating Area 1	No Preference	59	572.76
86545CT1230005	Rating Area 1	No Preference	60	597.19
86545CT1230005	Rating Area 1	No Preference	61	618.31
86545CT1230005	Rating Area 1	No Preference	62	632.17
86545CT1230005	Rating Area 1	No Preference	63	649.56
86545CT1230005	Rating Area 1	No Preference	64	660.12
86545CT1230005	Rating Area 1	No Preference	65 and over	660.12
86545CT1230005	Rating Area 2	No Preference	0-20	114.78
86545CT1230005	Rating Area 2	No Preference	21	180.75
86545CT1230005	Rating Area 2	No Preference	22	180.75
86545CT1230005	Rating Area 2	No Preference	23	180.75
86545CT1230005	Rating Area 2	No Preference	24	180.75
86545CT1230005	Rating Area 2	No Preference	25	181.47
86545CT1230005	Rating Area 2	No Preference	26	185.09
86545CT1230005	Rating Area 2	No Preference	27	189.43
86545CT1230005	Rating Area 2	No Preference	28	196.48
86545CT1230005	Rating Area 2	No Preference	29	202.26
86545CT1230005	Rating Area 2	No Preference	30	205.15
86545CT1230005	Rating Area 2	No Preference	31	209.49
86545CT1230005	Rating Area 2	No Preference	32	213.83
86545CT1230005	Rating Area 2	No Preference	33	216.54
86545CT1230005	Rating Area 2	No Preference	34	219.43
86545CT1230005	Rating Area 2	No Preference	35	220.88
86545CT1230005	Rating Area 2	No Preference	36	222.32
86545CT1230005	Rating Area 2	No Preference	37	223.77
86545CT1230005	Rating Area 2	No Preference	38	225.21
86545CT1230005	Rating Area 2	No Preference	39	228.11
86545CT1230005	Rating Area 2	No Preference	40	231.00
86545CT1230005	Rating Area 2	No Preference	41	235.34
86545CT1230005	Rating Area 2	No Preference	42	239.49
86545CT1230005	Rating Area 2	No Preference	43	245.28
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86545CT1480002	Rating Area 5	No Preference	21	344.29
86545CT1480002	Rating Area 5	No Preference	22	344.29
86545CT1480002	Rating Area 5	No Preference	23	344.29
86545CT1480002	Rating Area 5	No Preference	24	344.29

86545CT1480002	Rating Area 5	No Preference	25	345.67
86545CT1480002	Rating Area 5	No Preference	26	352.55
86545CT1480002	Rating Area 5	No Preference	27	360.82
86545CT1480002	Rating Area 5	No Preference	28	374.24
86545CT1480002	Rating Area 5	No Preference	29	385.26
86545CT1480002	Rating Area 5	No Preference	30	390.77
86545CT1480002	Rating Area 5	No Preference	31	399.03
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86545CT1480002	Rating Area 5	No Preference	33	412.46
86545CT1480002	Rating Area 5	No Preference	34	417.97
86545CT1480002	Rating Area 5	No Preference	35	420.72
86545CT1480002	Rating Area 5	No Preference	36	423.48
86545CT1480002	Rating Area 5	No Preference	37	426.23
86545CT1480002	Rating Area 5	No Preference	38	428.99
86545CT1480002	Rating Area 5	No Preference	39	434.49
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86545CT1480002	Rating Area 5	No Preference	46	516.44
86545CT1480002	Rating Area 5	No Preference	47	538.13
86545CT1480002	Rating Area 5	No Preference	48	562.91
86545CT1480002	Rating Area 5	No Preference	49	587.36
86545CT1480002	Rating Area 5	No Preference	50	614.90
86545CT1480002	Rating Area 5	No Preference	51	642.10
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86545CT1480002	Rating Area 5	No Preference	53	702.35
86545CT1480002	Rating Area 5	No Preference	54	735.06
86545CT1480002	Rating Area 5	No Preference	55	767.77
86545CT1480002	Rating Area 5	No Preference	56	803.23
86545CT1480002	Rating Area 5	No Preference	57	839.03
86545CT1480002	Rating Area 5	No Preference	58	877.25
86545CT1480002	Rating Area 5	No Preference	59	896.19
86545CT1480002	Rating Area 5	No Preference	60	934.40
86545CT1480002	Rating Area 5	No Preference	61	967.45
86545CT1480002	Rating Area 5	No Preference	62	989.15
86545CT1480002	Rating Area 5	No Preference	63	1016.34
86545CT1480002	Rating Area 5	No Preference	64	1032.87
86545CT1480002	Rating Area 5	No Preference	65 and over	1032.87
86545CT1480002	Rating Area 6	No Preference	0-20	211.72
86545CT1480002	Rating Area 6	No Preference	21	333.42
86545CT1480002	Rating Area 6	No Preference	22	333.42
86545CT1480002	Rating Area 6	No Preference	23	333.42
86545CT1480002	Rating Area 6	No Preference	24	333.42
86545CT1480002	Rating Area 6	No Preference	25	334.75
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86545CT1480002	Rating Area 6	No Preference	30	378.43
86545CT1480002	Rating Area 6	No Preference	31	386.43
86545CT1480002	Rating Area 6	No Preference	32	394.44
86545CT1480002	Rating Area 6	No Preference	33	399.44
86545CT1480002	Rating Area 6	No Preference	34	404.77
86545CT1480002	Rating Area 6	No Preference	35	407.44
86545CT1480002	Rating Area 6	No Preference	36	410.11
86545CT1480002	Rating Area 6	No Preference	37	412.77
86545CT1480002	Rating Area 6	No Preference	38	415.44
86545CT1480002	Rating Area 6	No Preference	39	420.78
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86545CT1480002	Rating Area 6	No Preference	42	441.78
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86545CT1480002	Rating Area 6	No Preference	44	465.79
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86545CT1480002	Rating Area 6	No Preference	46	500.13
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86545CT1480002	Rating Area 6	No Preference	52	650.84
86545CT1480002	Rating Area 6	No Preference	53	680.18
86545CT1480002	Rating Area 6	No Preference	54	711.85
86545CT1480002	Rating Area 6	No Preference	55	743.53
86545CT1480002	Rating Area 6	No Preference	56	777.87
86545CT1480002	Rating Area 6	No Preference	57	812.54
86545CT1480002	Rating Area 6	No Preference	58	849.55
86545CT1480002	Rating Area 6	No Preference	59	867.89
86545CT1480002	Rating Area 6	No Preference	60	904.90
86545CT1480002	Rating Area 6	No Preference	61	936.91
86545CT1480002	Rating Area 6	No Preference	62	957.92
86545CT1480002	Rating Area 6	No Preference	63	984.26
86545CT1480002	Rating Area 6	No Preference	64	1000.26
86545CT1480002	Rating Area 6	No Preference	65 and over	1000.26
86545CT1480002	Rating Area 7	No Preference	0-20	211.72
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86545CT1480002	Rating Area 7	No Preference	22	333.42
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86545CT1480002	Rating Area 7	No Preference	24	333.42
86545CT1480002	Rating Area 7	No Preference	25	334.75
86545CT1480002	Rating Area 7	No Preference	26	341.42
86545CT1480002	Rating Area 7	No Preference	27	349.42
86545CT1480002	Rating Area 7	No Preference	28	362.43
86545CT1480002	Rating Area 7	No Preference	29	373.10
86545CT1480002	Rating Area 7	No Preference	30	378.43
86545CT1480002	Rating Area 7	No Preference	31	386.43
86545CT1480002	Rating Area 7	No Preference	32	394.44
86545CT1480002	Rating Area 7	No Preference	33	399.44
86545CT1480002	Rating Area 7	No Preference	34	404.77
86545CT1480002	Rating Area 7	No Preference	35	407.44
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86545CT1480002	Rating Area 7	No Preference	37	412.77
86545CT1480002	Rating Area 7	No Preference	38	415.44
86545CT1480002	Rating Area 7	No Preference	39	420.78
86545CT1480002	Rating Area 7	No Preference	40	426.11
86545CT1480002	Rating Area 7	No Preference	41	434.11
86545CT1480002	Rating Area 7	No Preference	42	441.78
86545CT1480002	Rating Area 7	No Preference	43	452.45
86545CT1480002	Rating Area 7	No Preference	44	465.79
86545CT1480002	Rating Area 7	No Preference	45	481.46

86545CT1480002	Rating Area 7	No Preference	46	500.13
86545CT1480002	Rating Area 7	No Preference	47	521.14
86545CT1480002	Rating Area 7	No Preference	48	545.14
86545CT1480002	Rating Area 7	No Preference	49	568.81
86545CT1480002	Rating Area 7	No Preference	50	595.49
86545CT1480002	Rating Area 7	No Preference	51	621.83
86545CT1480002	Rating Area 7	No Preference	52	650.84
86545CT1480002	Rating Area 7	No Preference	53	680.18
86545CT1480002	Rating Area 7	No Preference	54	711.85
86545CT1480002	Rating Area 7	No Preference	55	743.53
86545CT1480002	Rating Area 7	No Preference	56	777.87
86545CT1480002	Rating Area 7	No Preference	57	812.54
86545CT1480002	Rating Area 7	No Preference	58	849.55
86545CT1480002	Rating Area 7	No Preference	59	867.89
86545CT1480002	Rating Area 7	No Preference	60	904.90
86545CT1480002	Rating Area 7	No Preference	61	936.91
86545CT1480002	Rating Area 7	No Preference	62	957.92
86545CT1480002	Rating Area 7	No Preference	63	984.26
86545CT1480002	Rating Area 7	No Preference	64	1000.26
86545CT1480002	Rating Area 7	No Preference	65 and over	1000.26
86545CT1480002	Rating Area 8	No Preference	0-20	211.72
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86545CT1480002	Rating Area 8	No Preference	22	333.42
86545CT1480002	Rating Area 8	No Preference	23	333.42
86545CT1480002	Rating Area 8	No Preference	24	333.42
86545CT1480002	Rating Area 8	No Preference	25	334.75
86545CT1480002	Rating Area 8	No Preference	26	341.42
86545CT1480002	Rating Area 8	No Preference	27	349.42
86545CT1480002	Rating Area 8	No Preference	28	362.43
86545CT1480002	Rating Area 8	No Preference	29	373.10
86545CT1480002	Rating Area 8	No Preference	30	378.43
86545CT1480002	Rating Area 8	No Preference	31	386.43
86545CT1480002	Rating Area 8	No Preference	32	394.44
86545CT1480002	Rating Area 8	No Preference	33	399.44
86545CT1480002	Rating Area 8	No Preference	34	404.77
86545CT1480002	Rating Area 8	No Preference	35	407.44
86545CT1480002	Rating Area 8	No Preference	36	410.11
86545CT1480002	Rating Area 8	No Preference	37	412.77
86545CT1480002	Rating Area 8	No Preference	38	415.44
86545CT1480002	Rating Area 8	No Preference	39	420.78
86545CT1480002	Rating Area 8	No Preference	40	426.11
86545CT1480002	Rating Area 8	No Preference	41	434.11
86545CT1480002	Rating Area 8	No Preference	42	441.78
86545CT1480002	Rating Area 8	No Preference	43	452.45
86545CT1480002	Rating Area 8	No Preference	44	465.79
86545CT1480002	Rating Area 8	No Preference	45	481.46
86545CT1480002	Rating Area 8	No Preference	46	500.13
86545CT1480002	Rating Area 8	No Preference	47	521.14
86545CT1480002	Rating Area 8	No Preference	48	545.14
86545CT1480002	Rating Area 8	No Preference	49	568.81
86545CT1480002	Rating Area 8	No Preference	50	595.49
86545CT1480002	Rating Area 8	No Preference	51	621.83
86545CT1480002	Rating Area 8	No Preference	52	650.84
86545CT1480002	Rating Area 8	No Preference	53	680.18
86545CT1480002	Rating Area 8	No Preference	54	711.85
86545CT1480002	Rating Area 8	No Preference	55	743.53
86545CT1480002	Rating Area 8	No Preference	56	777.87
86545CT1480002	Rating Area 8	No Preference	57	812.54
86545CT1480002	Rating Area 8	No Preference	58	849.55
86545CT1480002	Rating Area 8	No Preference	59	867.89
86545CT1480002	Rating Area 8	No Preference	60	904.90
86545CT1480002	Rating Area 8	No Preference	61	936.91
86545CT1480002	Rating Area 8	No Preference	62	957.92
86545CT1480002	Rating Area 8	No Preference	63	984.26
86545CT1480002	Rating Area 8	No Preference	64	1000.26
86545CT1480002	Rating Area 8	No Preference	65 and over	1000.26

Anthem

Individual Market

Anthem Silver PPO Standard Pathway X 4000/0%
86545CT1330001_00_STD_Silver_PPO_1/17_ENG 2J6M

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	 $4,000 per Member $8,000 per family	 $6,000 per Member $12,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$150 per Member $300 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per family	 $12,500 per Member $25,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	40% Coinsurance per visit

Infant/Pediatric Preventive Visit	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans.	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met

Tier 2	$35 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3	$60 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$87.50 Copayment per prescription	Not Covered
Tier 3	$150.00 Copayment per prescription	Not Covered
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply	40% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item	40% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day up to $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	$200 Copayment per visit	$200 Copayment per visit
Urgent Care Centers	$75 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Standard Pathway X
86545CT1330001_01_STD_Silver_PPO_1/17_ENG 2ER2

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	 $4,000 per Member $8,000 per family	 $6,000 per Member $12,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$150 per Member $300 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per family	 $12,500 per Member $25,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	40% Coinsurance per visit

Infant/Pediatric Preventive Visit	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans.	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met

Tier 2	$35 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3	$60 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$87.50 Copayment per prescription	Not Covered
Tier 3	$150.00 Copayment per prescription	Not Covered
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply	40% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item	40% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day up to $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	$200 Copayment per visit	$200 Copayment per visit
Urgent Care Centers	$75 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Standard Pathway X ZCSR
86545CT1330001_02_STD_Silver_PPO_1/17_ENG 2ER7

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$0 per Member	$0 per Member
family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	No Cost
Infant/Pediatric Preventive Visit	No Cost	No Cost

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost	No Cost
Specialist Office Visits	No Cost	No Cost
Mental Health and Substance Abuse Office Visit	No Cost	No Cost
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	No Cost	No Cost
Tier 2	No Cost	No Cost
Tier 3	No Cost	No Cost
Tier 4	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	No Cost	Not Covered
Tier 2	No Cost	Not Covered
Tier 3	No Cost	Not Covered
Tier 4	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost	No Cost
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost	No Cost
Diabetic Equipment and Supplies	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost	No Cost
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	No Cost	No Cost

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	No Cost	No Cost

Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	No Cost	No Cost
Major Services	No Cost	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost	No Cost
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Standard Pathway X LCSR
86545CT1330001_03_STD_Silver_PPO_1/17_ENG 2ER6

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	 $4,000 per Member $8,000 per family	 $6,000 per Member $12,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$150 per Member $300 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per family	 $12,500 per Member $25,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	40% Coinsurance per visit

		No Member cost when services are rendered by an Indian Health Service Provider
Infant/Pediatric Preventive Visit	No Cost	40% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans. No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Laboratory Services	$10 Copayment per service No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Mammography Ultrasound	$20 Copayment per service No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per prescription after OON prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Tier 2	$35 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per prescription after OON prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	$60 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per prescription after OON prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $200 per prescription No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per prescription after OON prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 2	$87.50 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 3	$150.00 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered

Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per equipment or supply after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	40% Coinsurance per DME item No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per DME item after OON plan Deductible is met No Member cost when services are rendered by an

		Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	$0 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day up to $2,000 per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance No Member cost when services are rendered by an Indian Health Service Provider	0% Coinsurance No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	$200 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	$200 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$75 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	40% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	50% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider	Not Covered No Member cost when services are rendered by an Indian Health Service Provider

Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit ater OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to

us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem

Individual Market

Silver PPO Standard Pathway X 73% CSR
86545CT1330001_04_STD_Silver_PPO_1/17_ENG 2ER3

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	 $3,400 per Member $6,800 per family	 $6,000 per Member $12,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$100 per Member $200 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	 $5,700 per Member $11,400 per family	 $12,500 per Member $25,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	40% Coinsurance per visit

Infant/Pediatric Preventive Visit	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans.	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met

Tier 2	$35 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3	$60 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$87.50 Copayment per prescription	Not Covered
Tier 3	$150.00 Copayment per prescription	Not Covered
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply	40% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item	40% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day up to $2,000 per Admission after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	$200 Copayment per visit	$200 Copayment per visit
Urgent Care Centers	$75 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

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Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Standard Pathway X 87% CSR
86545CT1330001_05_STD_Silver_PPO_1/17_ENG 2ER4

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	 $700 per Member $1,400 per family	 $6,000 per Member $12,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$50 per Member $100 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	 $1,800 per Member $3,600 per family	 $12,500 per Member $25,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	40% Coinsurance per visit

Infant/Pediatric Preventive Visit	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$60 Copayment per service Up to a combined annual maximum of $360 for MRI and CAT scans; **$**400 for PET scans.	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$30 Copayment per service	40% Coinsurance per service after OON plan Deductible is met

Mammography Ultrasound	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met

Tier 2	$20 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3	$35 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $60 per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$50 Copayment per prescription	Not Covered
Tier 3	$87.50 Copayment per prescription	Not Covered
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply	40% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item	40% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$100 Copayment per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$100 Copayment per day up to $400 per Admission after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	$75 Copayment per visit	$75 Copayment per visit
Urgent Care Centers	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Standard Pathway X 94% CSR
86545CT1330001_06_STD_Silver_PPO_1/17_ENG 2ER5

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	 $0 per Member $0 per family	 $6,000 per Member $12,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$0 per Member $0 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	 $1,000 per Member $2,000 per family	 $12,500 per Member $25,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	40% Coinsurance per visit

Infant/Pediatric Preventive Visit	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$10 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$10 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$50 Copayment per service Up to a combined annual maximum of $350 for MRI and CAT scans; **$**400 for PET scans.	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$25 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met

Tier 2	$10 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3	$30 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 4	20% Coinsurance per prescription up to a maximum of $60 per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$25 Copayment per prescription	Not Covered
Tier 3	$75 Copayment per prescription	Not Covered
Tier 4	20% Coinsurance per prescription	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services	$30 Copayment per visit	40% Coinsurance per visit

(up to 20 visits per Calendar Year)		after OON plan Deductible is met
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply	40% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item	40% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No cost	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$75 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$75 Copayment per day up to a maximum of $300 per Admission	40% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	$50 Copayment per visit	$50 Copayment per visit
Urgent Care Centers	$25 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is

		met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$30 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Anthem Bronze PPO Standard Pathway X 6000/0%
86545CT1330002_00_STD_Bronze_PPO_1/17_ENG 2J6C

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$6,000 per Member	$10,000 per Member
family	$12,000 per family	$20,000 per family
Out-of-Pocket Maximum **Individual**	$7,150 per Member	$13,200 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$14,300 per family	$26,400 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans.	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound	$20 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		

Tier 1	$5 Copayment per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription after INET plan Deductible is met	Not Covered
Tier 2	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	$0 Copayment per visit after INET plan Deductible is met	$0 Copayment per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$75 Copayment per visit	50% Coinsurance per visit

		after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	45% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Bronze PPO Standard Pathway X
86545CT1330002_01_STD_Bronze_PPO_1/17_ENG 2J6N

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$6,000 per Member	$10,000 per Member
family	$12,000 per family	$20,000 per family
Out-of-Pocket Maximum **Individual**	$7,150 per Member	$13,200 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$14,300 per family	$26,400 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans.	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound	$20 Copayment per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		

Tier 1	$5 Copayment per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription after INET plan Deductible is met	Not Covered
Tier 2	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 per day up to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	No Cost per visit after INET plan Deductible is met	No Cost per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$75 Copayment per visit	50% Coinsurance per visit

		after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	45% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Bronze PPO Standard Pathway X ZCSR
86545CT1330002_02_STD_Bronze_PPO_1/17_ENG 1J6T

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$0 per Member	$0 per Member
family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	No Cost
Infant/Pediatric Preventive Visit	No Cost	No Cost

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost	No Cost
Specialist Office Visits	No Cost	No Cost
Mental Health and Substance Abuse Office Visit	No Cost	No Cost
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	No Cost	No Cost
Tier 2	No Cost	No Cost
Tier 3	No Cost	No Cost
Tier 4	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	No Cost	Not Covered
Tier 2	No Cost	Not Covered
Tier 3	No Cost	Not Covered
Tier 4	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost	No Cost
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost	No Cost
Diabetic Equipment and Supplies	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost	No Cost
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	No Cost	No Cost

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	No Cost	No Cost

Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	No Cost	No Cost
Major Services	No Cost	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost	No Cost
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Bronze PPO Standard Pathway X LCSR
86545CT1330002_03_STD_Bronze_PPO_1/17_ENG 2J6S

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	\$6,000 per Member	\$10,000 per Member
family	\$12,000 per family	\$20,000 per family
Out-of-Pocket Maximum **Individual**	\$7,150 per Member	\$13,200 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	\$14,300 per family	\$26,400 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

		No Member cost when services are rendered by an Indian Health Service Provider
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	$50 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans. No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Laboratory Services	$10 Copayment per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Mammography Ultrasound	$20 Copayment per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Tier 2	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 2	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered

Tier 4	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per equipment or supply after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	40% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per DME item after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service

		Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per stay after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 per day up to a maximum of $1,000 per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Emergency and Urgent Care		
Ambulance Services	$0 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	$0 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	$200 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	$200 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$75 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service

		Provider
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	45% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	50% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services	Not Covered No Member cost when services are rendered by an Indian Health Service Provider

	are rendered by an Indian Health Service Provider	
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that

identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem

Individual Market

Anthem Gold PPO Standard Pathway X 1550/0%
86545CT1330003_00_STD_Gold_PPO_1/17_ENG 2J6F

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	$1,550 per Member $3,100 per family	$3,000 per Member $6,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$25 per Member $50 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	$3,500 per Member $7,000 per family	$6,000 per Member $12,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	30% Coinsurance per visit

Infant/Pediatric Preventive Visit	No Cost	30% Coinsurance per visit
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$65 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans.	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service	30% Coinsurance per service after OON plan Deductible is met

Mammography Ultrasound	$20 Copayment per service	30% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	30% Coinsurance per prescription after OON prescription drug Deductible is met

Tier 2	$25 Copayment per prescription	30% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3	$50 Copayment per prescription	30% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	30% Coinsurance per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$62.50 Copayment per prescription	Not Covered
Tier 3	$125 Copayment per prescription	Not Covered
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met

Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	30% Coinsurance per equipment or supply	30% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	30% Coinsurance per DME item	30% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day up to $1,000 per Admission after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	$100 Copayment per visit	$100 Copayment per visit
Urgent Care Centers	$50 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	20% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Major Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Gold PPO Standard Pathway X
86545CT1330003_01_STD_Gold_PPO_1/17_ENG 2J6U

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	 $1,550 per Member $3,100 per family	 $3,000 per Member $6,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$25 per Member $50 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	 $3,500 per Member $7,000 per family	 $6,000 per Member $12,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	30% Coinsurance per visit

Infant/Pediatric Preventive Visit	No Cost	30% Coinsurance per visit
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$65 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans.	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Mammography Ultrasound	$20 Copayment per service	30% Coinsurance per service after OON plan Deductible is met
Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	30% Coinsurance per prescription after OON prescription drug Deductible is met

Tier 2	$25 Copayment per prescription	30% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3	$50 Copayment per prescription	30% Coinsurance per prescription after OON prescription drug plan Deductible is met
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription	30% Coinsurance per prescription after OON prescription drug Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$62.50 Copayment per prescription	Not Covered
Tier 3	$125 Copayment per prescription	Not Covered
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$20 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met

Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	30% Coinsurance per equipment or supply	30% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	30% Coinsurance per DME item	30% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day up to $1,000 per Admission after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	$100 Copayment per visit	$100 Copayment per visit
Urgent Care Centers	$50 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	20% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met

Major Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Gold PPO Standard Pathway X ZCSR
86545CT1330003_02_STD_Gold_PPO_1/17_ENG 2J6W

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$0 per Member	$0 per Member
family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	No Cost
Infant/Pediatric Preventive Visit	No Cost	No Cost

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost	No Cost
Specialist Office Visits	No Cost	No Cost
Mental Health and Substance Abuse Office Visit	No Cost	No Cost
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	No Cost	No Cost
Tier 2	No Cost	No Cost
Tier 3	No Cost	No Cost
Tier 4	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	No Cost	Not Covered
Tier 2	No Cost	Not Covered
Tier 3	No Cost	Not Covered
Tier 4	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost	No Cost
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost	No Cost
Diabetic Equipment and Supplies	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost	No Cost
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	No Cost	No Cost

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	No Cost	No Cost

Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	No Cost	No Cost
Major Services	No Cost	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost	No Cost
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Gold PPO Standard Pathway X LCSR
86545CT1330003_03_STD_Gold_PPO_1/17_ENG 2J6V

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual** **family**	$1,550 per Member $3,100 per family	$3,000 per Member $6,000 per family
Separate Prescription Drug Deductible **Individual** **family**	$25 per Member $50 per family	$350 per Member $700 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductibles, Copayments and Coinsurance)**	$3,500 per Member $7,000 per family	$6,000 per Member $12,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	30% Coinsurance per visit

		No Member cost when services are rendered by an Indian Health Service Provider
Infant/Pediatric Preventive Visit	No Cost	30% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$20 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	$40 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$20 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$65 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans. No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Laboratory Services	$10 Copayment per service No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Mammography Ultrasound	$20 Copayment per service No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per prescription after OON prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Tier 2	$25 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per prescription after OON prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	$50 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per prescription after OON prescription drug plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $100 per prescription No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per prescription after OON prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 2	$62.50 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 3	$125 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered

Tier 4	20% Coinsurance per prescription after INET prescription drug Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$20 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$20 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$40 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	30% Coinsurance per equipment or supply No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per equipment or supply after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	30% Coinsurance per DME item No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per DME item after OON plan Deductible is met No Member cost when services are rendered by an

		Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day up to $1,000 per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Emergency and Urgent Care		
Ambulance Services	No Cost No Member cost when services are rendered by an Indian Health Service Provider	No Cost No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	$100 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	$100 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	20% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	40% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider	Not Covered No Member cost when services are rendered by an Indian Health Service Provider

Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$40 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	30% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Prescription Drug Deductible. This Plan includes a Prescription Drug Deductible in addition to the Deductible for Medical, Pediatric Dental and Pediatric Vision Services. The Prescription Drug Deductible and Deductible for other Covered Services are separate; amounts applied to one do not apply to the other. Please refer to the Prescription Drug benefits later in this section for more details about the Prescription Drug Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to

us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem

Individual Market

Anthem Silver PPO Pathway X 3500/0%
86545CT1330004_00_NSTD_Silver_PPO_1/17_ENG 2J6L

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$3,500 per Member	$6,500 per Member
family	$10,500 per family	$13,000 per family
Out-of-Pocket Maximum **Individual**	$6,000 per Member	$9,750 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$12,000 per family	$19,500 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits $25 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$60 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met

Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$150 Copayment per prescription	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is

		met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after	50% Coinsurance per visit

	INET plan Deductible is met	after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X
86545CT1330004_01_NSTD_Silver_PPO_1/17_ENG 2J6X

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$3,500 per Member	$10,500 per Member
family	$10,500 per family	$31,500 per family
Out-of-Pocket Maximum **Individual**	$6,000 per Member	$18,000 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$12,000 per family	$36,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits $25 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$60 Copayment per prescription	

Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$150 Copayment per prescription	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is

		met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after	50% Coinsurance per visit

	INET plan Deductible is met	after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X ZCSR
86545CT1330004_02_NSTD_Silver_PPO_1/17_ENG 2J72

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$0 per Member	$0 per Member
family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	No Cost
Infant/Pediatric Preventive Visit	No Cost	No Cost

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost	No Cost
Specialist Office Visits	No Cost	No Cost
Mental Health and Substance Abuse Office Visit	No Cost	No Cost
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	No Cost	No Cost
Tier 2	No Cost	No Cost
Tier 3	No Cost	No Cost
Tier 4	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	No Cost	Not Covered
Tier 2	No Cost	Not Covered
Tier 3	No Cost	Not Covered
Tier 4	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost	No Cost
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost	No Cost
Diabetic Equipment and Supplies	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost	No Cost
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	No Cost	No Cost

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	No Cost	No Cost

Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	No Cost	No Cost
Major Services	No Cost	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost	No Cost
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X LCSR
86545CT1330004_03_NSTD_Silver_PPO_1/17_ENG 2J71

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$3,500 per Member	$10,500 per Member
family	$10,500 per family	$31,500 per family
Out-of-Pocket Maximum **Individual**	$6,000 per Member	$18,000 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$12,000 per family	$36,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits $25 Copayment per online visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Laboratory Services	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	$60 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 2	$150 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per equipment or supply after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per DME item after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service

		Provider
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	$200 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	$200 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost No Member cost when services	No Cost No Member cost when

	are rendered by an Indian Health Service Provider	services are rendered by an Indian Health Service Provider
Basic Services	40% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	50% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an

		Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem

Individual Market

Silver PPO Pathway X 73% CSR
86545CT1330004_04_NSTD_Silver_PPO_1/17_ENG 2J6Y

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$2,900 per Member	$9,600 per Member
family	$5,800 per family	$19,200 per family
Out-of-Pocket Maximum **Individual**	$5,500 per Member	$15,300 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$11,000 per family	$30,600 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$30 Copayment per visit Deductible is waived for first 3 visits $20 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$30 Copayment per visit Deductible is waived for first 3 visits	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$55 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met

Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$137.50 Copayment per prescription	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is

		met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after	50% Coinsurance per visit

	INET plan Deductible is met	after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X 87% CSR
86545CT1330004_05_NSTD_Silver_PPO_1/17_ENG 2J6Z

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$1,000 per Member	$9,600 per Member
family	$2,000 per family	$19,200 per family
Out-of-Pocket Maximum **Individual**	$1,500 per Member	$15,300 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$3,000 per family	$30,600 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	30% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	30% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$20 Copayment per visit Deductible is waived for first 3 visits $15 Copayment per online visit	30% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$20 Copayment per visit Deductible is waived for first 3 visits	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	30% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$35 Copayment per prescription	30% Coinsurance per prescription after OON plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	30% Coinsurance per prescription after OON plan Deductible is met

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	30% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$87.50 Copayment per prescription	Not Covered
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	30% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is	30% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$250 Copayment per Admission after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$100 Copayment per visit after INET plan Deductible is met	$100 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X 94% CSR
86545CT1330004_06_NSTD_Silver_PPO_1/17_ENG 2J70

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$300 per Member	$9,600 per Member
family	$600 per family	$19,200 per family
Out-of-Pocket Maximum **Individual**	$600 per Member	$15,300 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$1,200 per family	$30,600 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	30% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	30% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$15 Copayment per visit Deductible is waived for first 3 visits $10 Copayment per online visit	30% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$15 Copayment per visit Deductible is waived for first 3 visits	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	30% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$35 Copayment per prescription	30% Coinsurance per prescription after OON plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	30% Coinsurance per prescription after OON plan Deductible is met

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	30% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$87.50 Copayment per prescription	Not Covered
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	30% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is	30% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$150 Copayment per Admission after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$75 Copayment per visit after INET plan Deductible is met	$75 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$25 Copayment per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Anthem Bronze PPO Standard Pathway X 5650/11300/10% for HSA
86545CT1330009_00_STD_Bronze_PPO_1/17_ENG 2J6B

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$5,685 per Member	$9,200 per Member
family	$11,370 per family	$18,400 per family
Out-of-Pocket Maximum **Individual**	$6,550 per Member	$12,900 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$13,100 per family	$25,800 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	10% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	15% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	25% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	10% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2	15% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3	25% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	30% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	10% Coinsurance per equipment or supply after INET	50% Coinsurance per equipment or supply after

	plan Deductible is met	OON plan Deductible is met
Durable Medical Equipment (DME)	10% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	10% Coinsurance after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per visit after INET plan Deductible is met	10% Coinsurance per visit after INET plan Deductible is met
Emergency Room	10% Coinsurance after INET plan Deductible is met	10% Coinsurance after INET plan Deductible is met
Urgent Care Centers	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services	50% Coinsurance per visit after	50% Coinsurance per visit

(Medically Necessary only)	INET plan Deductible is met	after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Bronze PPO Standard Pathway X for HSA
86545CT1330009_01_STD_Bronze_PPO_1/17_ENG 2J6P

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$5,685 per Member	$9,200 per Member
family	$11,370 per family	$18,400 per family
Out-of-Pocket Maximum **Individual**	$6,550 per Member	$12,900 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$13,100 per family	$25,800 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	10% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	15% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	25% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	10% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2	15% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3	25% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	30% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	10% Coinsurance per equipment or supply after INET	50% Coinsurance per equipment or supply after

	plan Deductible is met	OON plan Deductible is met
Durable Medical Equipment (DME)	10% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	10% Coinsurance after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	10% Coinsurance per visit after INET plan Deductible is met	10% Coinsurance per visit after INET plan Deductible is met
Emergency Room	10% Coinsurance after INET plan Deductible is met	10% Coinsurance after INET plan Deductible is met
Urgent Care Centers	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services	50% Coinsurance per visit after	50% Coinsurance per visit

(Medically Necessary only)	INET plan Deductible is met	after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	10% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Bronze PPO Standard Pathway X for HSA ZCSR
86545CT1330009_02_STD_Bronze_PPO_1/17_ENG 2J6R

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$0 per Member	$0 per Member
family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	No Cost
Infant/Pediatric Preventive Visit	No Cost	No Cost

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost	No Cost
Specialist Office Visits	No Cost	No Cost
Mental Health and Substance Abuse Office Visit	No Cost	No Cost
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	No Cost	No Cost
Tier 2	No Cost	No Cost
Tier 3	No Cost	No Cost
Tier 4	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	No Cost	Not Covered
Tier 2	No Cost	Not Covered
Tier 3	No Cost	Not Covered
Tier 4	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost	No Cost
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost	No Cost
Diabetic Equipment and Supplies	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost	No Cost
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	No Cost	No Cost

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	No Cost	No Cost

Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	No Cost	No Cost
Major Services	No Cost	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost	No Cost
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Bronze PPO Standard Pathway X for HSA LCSR
86545CT1330009_03_STD_Bronze_PPO_1/17_ENG 2J6Q

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$5,685 per Member	$9,200 per Member
family	$11,370 per family	$18,400 per family
Out-of-Pocket Maximum **Individual**	$6,550 per Member	$12,900 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$13,100 per family	$25,800 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

		No Member cost when services are rendered by an Indian Health Service Provider
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	10% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Laboratory Services	10% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Non-Advanced Radiology (X-ray, Diagnostic)	10% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	10% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	15% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	25% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	30% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		

Tier 1	10% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 2	15% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 3	25% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 4	30% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services		
Chiropractic Services	10% Coinsurance per visit after	50% Coinsurance per visit

(up to 20 visits per Calendar Year)	INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	10% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per equipment or supply after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	10% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per DME item after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	10% Coinsurance after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency and Urgent Care		

Ambulance Services	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	10% Coinsurance after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	10% Coinsurance after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	40% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	50% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services	50% Coinsurance per visit after	50% Coinsurance per visit

(Medically Necessary only)	INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider	Not Covered No Member cost when services are rendered by an Indian Health Service Provider
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	10% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem

Individual Market

Silver Core PPO Pathway X 5300
86545CT1330010_00_NSTD_Silver_PPO_1/17_ENG 2ERD

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$5,300 per Member	$15,900 per Member
family	$10,600 per family	$31,800 per family
Out-of-Pocket Maximum **Individual**	$6,750 per Member	$20,250 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$13,500 per family	$40,500 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit $25 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$40 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$100.00 Copayment per prescription	Not Covered
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	25% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	25% Coinsurance per DME item after INET plan Deductible is	50% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	25% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Adult Vision Care (for Members age 19 and older).		
Benefits	**In-Network (INET)** **Member Pays**	**Out-of Network (OON)** **Reimbursement**
Routine Eye Exam One eye exam per Calendar Year	25% Coinsurance per visit after INET plan Deductible is met	$30 Copayment per visit after OON plan Deductible is met
Standard Plastic Lenses Once every other Calendar Year.		
Single Vision	$20 Copayment after INET plan Deductible is met	$25 Copayment after OON plan Deductible is met
Bifocal	$20 Copayment after INET plan Deductible is met	$40 Copayment after OON plan Deductible is met
Trifocal	$20 Copayment after INET plan Deductible is met	$55 Copayment after OON plan Deductible is met
Frames One frame every other Calendar Year	$130 Allowance after INET plan Deductible is met	Up to $45 after OON plan Deductible is met
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	$80 Allowance after INET plan Deductible is met	Up to $60 after OON plan Deductible is met
Non-Elective	Covered in full after INET plan Deductible is met	Up to $210 after OON plan Deductible is met

Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver Core PPO Pathway X 5300
86545CT1330010_01_NSTD_Silver_PPO_1/17_ENG 2ER9

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$5,300 per Member	$15,900 per Member
family	$10,600 per family	$31,800 per family
Out-of-Pocket Maximum **Individual**	$6,750 per Member	$20,250 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$13,500 per family	$40,500 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit $25 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$40 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$100.00 Copayment per prescription	Not Covered
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	25% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	25% Coinsurance per DME item after INET plan Deductible is	50% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	25% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Adult Vision Care (for Members age 19 and older).		
Benefits	**In-Network (INET)** **Member Pays**	**Out-of Network (OON)** **Reimbursement**
Routine Eye Exam One eye exam per Calendar Year	25% Coinsurance per visit after INET plan Deductible is met	$30 Copayment per visit after OON plan Deductible is met
Standard Plastic Lenses Once every other Calendar Year.		
Single Vision	$20 Copayment after INET plan Deductible is met	$25 Copayment after OON plan Deductible is met
Bifocal	$20 Copayment after INET plan Deductible is met	$40 Copayment after OON plan Deductible is met
Trifocal	$20 Copayment after INET plan Deductible is met	$55 Copayment after OON plan Deductible is met
Frames One frame every other Calendar Year	$130 Allowance after INET plan Deductible is met	Up to $45 after OON plan Deductible is met
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	$80 Allowance after INET plan Deductible is met	Up to $60 after OON plan Deductible is met
Non-Elective	Covered in full after INET plan Deductible is met	Up to $210 after OON plan Deductible is met

Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver Core PPO Pathway X 5300 ZCSR
86545CT1330010_02_NSTD_Silver_PPO_1/17_ENG 2ERF

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$0 per Member	$0 per Member
family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	No Cost
Infant/Pediatric Preventive Visit	No Cost	No Cost

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost	No Cost
Specialist Office Visits	No Cost	No Cost
Mental Health and Substance Abuse Office Visit	No Cost	No Cost
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	No Cost	No Cost
Tier 2	No Cost	No Cost
Tier 3	No Cost	No Cost
Tier 4	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	No Cost	Not Covered
Tier 2	No Cost	Not Covered
Tier 3	No Cost	Not Covered
Tier 4	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost	No Cost
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost	No Cost
Diabetic Equipment and Supplies	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost	No Cost
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	No Cost	No Cost

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	No Cost	No Cost

Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	No Cost	No Cost
Major Services	No Cost	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost	No Cost
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	No Cost

Adult Vision Care (for Members age 19 and older).		
Benefits	**In-Network (INET)** **Member Pays**	**Out-of Network (OON)** **Reimbursement**
Routine Eye Exam One eye exam per Calendar Year	No Cost	$30 Copayment per visit after OON plan Deductible is met
Standard Plastic Lenses Once every other Calendar Year.		
Single Vision	$20 Copayment after INET plan Deductible is met	$25 Copayment after OON plan Deductible is met
Bifocal	$20 Copayment after INET plan Deductible is met	$40 Copayment after OON plan Deductible is met

Trifocal	$20 Copayment after INET plan Deductible is met	$55 Copayment after OON plan Deductible is met
Frames One frame every other Calendar Year	$130 Allowance after INET plan Deductible is met	Up to $45 after OON plan Deductible is met
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	$80 Allowance after INET plan Deductible is met	Up to $60 after OON plan Deductible is met
Non-Elective	Covered in full after INET plan Deductible is met	Up to $210 after OON plan Deductible is met
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options

every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver Core PPO Pathway X 5300 LCSR
86545CT1330010_03_NSTD_Silver_PPO_1/17_ENG 2ERE

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$5,300 per Member	$15,900 per Member
family	$10,600 per family	$31,800 per family
Out-of-Pocket Maximum **Individual**	$6,750 per Member	$20,250 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$13,500 per family	$40,500 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

		No Member cost when services are rendered by an Indian Health Service Provider
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit $25 Copayment per online visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	$40 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		

Tier 1	$10 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 2	$100.00 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services	50% Coinsurance per visit after OON plan Deductible is met

	are rendered by an Indian Health Service Provider	No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	25% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per equipment or supply after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	25% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per DME item after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	25% Coinsurance per stay after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency and Urgent Care		

Ambulance Services	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost No Member cost when services are rendered by an Indian Health Service Provider	No Cost No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	40% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	50% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is

	No Member cost when services are rendered by an Indian Health Service Provider	met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Adult Vision Care (for Members age 19 and older).		
Benefits	**In-Network (INET)** **Member Pays**	**Out-of Network (OON)** **Reimbursement**
Routine Eye Exam One eye exam per Calendar Year	25% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	$30 Copayment per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Standard Plastic Lenses Once every other Calendar Year.		
Single Vision	$20 Copayment after INET plan Deductible is met	$25 Copayment after OON plan Deductible is met

	No Member cost when services are rendered by an Indian Health Service Provider	No Member cost when services are rendered by an Indian Health Service Provider
Bifocal	$20 Copayment after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	$40 Copayment after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Trifocal	$20 Copayment after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	$55 Copayment after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Frames One frame every other Calendar Year	$130 Allowance after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Up to $45 after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	$80 Allowance after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Up to $60 after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Elective	Covered in full after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Up to $210 after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem

Individual Market

Silver Core PPO Pathway X 5300 73% CSR
86545CT1330010_04_NSTD_Silver_PPO_1/17_ENG 2ERA

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$4,000 per Member	$12,000 per Member
family	$8,000 per family	$24,000 per family
Out-of-Pocket Maximum **Individual**	$5,500 per Member	$16,500 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$11,000 per family	$33,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit $25 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$40 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$100.00 Copayment per prescription	Not Covered
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	25% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	25% Coinsurance per DME item after INET plan Deductible is	50% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	25% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Adult Vision Care (for Members age 19 and older).		
Benefits	**In-Network (INET)** **Member Pays**	**Out-of Network (OON)** **Reimbursement**
Routine Eye Exam One eye exam per Calendar Year	25% Coinsurance per visit after INET plan Deductible is met	$30 Copayment per visit after OON plan Deductible is met
Standard Plastic Lenses Once every other Calendar Year.		
Single Vision	$20 Copayment after INET plan Deductible is met	$25 Copayment after OON plan Deductible is met
Bifocal	$20 Copayment after INET plan Deductible is met	$40 Copayment after OON plan Deductible is met
Trifocal	$20 Copayment after INET plan Deductible is met	$55 Copayment after OON plan Deductible is met
Frames One frame every other Calendar Year	$130 Allowance after INET plan Deductible is met	Up to $45 after OON plan Deductible is met
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	$80 Allowance after INET plan Deductible is met	Up to $60 after OON plan Deductible is met
Non-Elective	Covered in full after INET plan Deductible is met	Up to $210 after OON plan Deductible is met

Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver Core PPO Pathway X 5300 87% CSR
86545CT1330010_05_NSTD_Silver_PPO_1/17_ENG 2ERB

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$1,000 per Member	$3,000 per Member
family	$2,000 per family	$6,000 per family
Out-of-Pocket Maximum **Individual**	$1,850 per Member	$5,550 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$3,700 per family	$11,100 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$30 Copayment per visit $20 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$40 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$100.00 Copayment per prescription	Not Covered
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	25% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	25% Coinsurance per DME item after INET plan Deductible is	50% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	25% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Adult Vision Care (for Members age 19 and older).		
Benefits	**In-Network (INET)** **Member Pays**	**Out-of Network (OON)** **Reimbursement**
Routine Eye Exam One eye exam per Calendar Year	25% Coinsurance per visit after INET plan Deductible is met	$30 Copayment per visit after OON plan Deductible is met
Standard Plastic Lenses Once every other Calendar Year.		
Single Vision	$20 Copayment after INET plan Deductible is met	$25 Copayment after OON plan Deductible is met
Bifocal	$20 Copayment after INET plan Deductible is met	$40 Copayment after OON plan Deductible is met
Trifocal	$20 Copayment after INET plan Deductible is met	$55 Copayment after OON plan Deductible is met
Frames One frame every other Calendar Year	$130 Allowance after INET plan Deductible is met	Up to $45 after OON plan Deductible is met
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	$80 Allowance after INET plan Deductible is met	Up to $60 after OON plan Deductible is met
Non-Elective	Covered in full after INET plan Deductible is met	Up to $210 after OON plan Deductible is met

Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver Core PPO Pathway X 5300 94% CSR
86545CT1330010_06_NSTD_Silver_PPO_1/17_ENG 2ERC

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$250 per Member	$750 per Member
family	$500 per family	$1,500 per family
Out-of-Pocket Maximum **Individual**	$750 per Member	$2,250 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$1,500 per family	$4,500 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$25 Copayment per visit $15 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$25 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	25% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$25 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$62.50 Copayment per prescription	Not Covered
Tier 3	35% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	25% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	25% Coinsurance per DME item after INET plan Deductible is	50% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	25% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	25% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Emergency Room	25% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	25% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Adult Vision Care (for Members age 19 and older).		
Benefits	**In-Network (INET)** **Member Pays**	**Out-of Network (OON)** **Reimbursement**
Routine Eye Exam One eye exam per Calendar Year	25% Coinsurance per visit after INET plan Deductible is met	$30 Copayment per visit after OON plan Deductible is met
Standard Plastic Lenses Once every other Calendar Year.		
Single Vision	$20 Copayment after INET plan Deductible is met	$25 Copayment after OON plan Deductible is met
Bifocal	$20 Copayment after INET plan Deductible is met	$40 Copayment after OON plan Deductible is met
Trifocal	$20 Copayment after INET plan Deductible is met	$55 Copayment after OON plan Deductible is met
Frames One frame every other Calendar Year	$130 Allowance after INET plan Deductible is met	Up to $45 after OON plan Deductible is met
Contact Lenses Once every other Calendar Year		
Elective (conventional and disposable)	$80 Allowance after INET plan Deductible is met	Up to $60 after OON plan Deductible is met
Non-Elective	Covered in full after INET plan Deductible is met	Up to $210 after OON plan Deductible is met

Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA
86545CT1340005_00_NSTD_Bronze_PPO_1/17_ENG 2J69

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$5,700 per Member	$17,100 per Member
family	$11,400 per family	$34,200 per family
Out-of-Pocket Maximum **Individual**	$6,550 per Member	$19,650 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$13,100 per family	$39,300 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	20% Coinsurance per visit after INET plan Deductible is met 20% Coinsurance per online visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	20% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	20% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	20% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	20% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	20% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2	20% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3	20% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	20% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	20% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met

Durable Medical Equipment (DME)	20% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	20% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	20% Coinsurance per visit after INET plan Deductible is met	20% Coinsurance per visit after INET plan Deductible is met
Emergency Room	20% Coinsurance per visit after INET plan Deductible is met	20% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options

every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Anthem Silver PPO Century Preferred 2750
86545CT1340006_00_NSTD_Silver_PPO_1/17_ENG 2J6H

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$2,750 per Member	$8,250 per Member
family	$8,250 per family	$24,750 per family
Out-of-Pocket Maximum **Individual**	$7,150 per Member	$21,450 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$14,300 per family	$42,900 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$35 Copayment per visit $25 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$35 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	50% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$60 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$150 Copayment per prescription	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	20% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met

Durable Medical Equipment (DME)	20% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	20% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	50% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	20% Coinsurance per visit after INET plan Deductible is met	20% Coinsurance per visit after INET plan Deductible is met
Emergency Room	20% Coinsurance per visit after INET plan Deductible is met	20% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans

and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Anthem Bronze PPO Century Preferred 7150/0%
86545CT1340010_00_NSTD_Bronze_PPO_1/17_ENG 2J6A

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$7,150 per Member	$21,450 per Member
family	$14,300 per family	$42,900 per family
Out-of-Pocket Maximum **Individual**	$7,150 per Member	$21,450 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$14,300 per family	$42,900 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	0% Coinsurance per visit after INET plan Deductible is met 0% Coinsurance per online visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met

Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	0% Coinsurance per day after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met

Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans

and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Anthem Silver PPO Century Preferred 3000/6000 for HSA
86545CT1340011_00_NSTD_Silver_PPO_1/17_ENG 2J6J

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$3,000 per Member	$9,000 per Member
family	$6,000 per family	$18,000 per family
Out-of-Pocket Maximum **Individual**	$4,850 per Member	$14,550 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$9,700 per family	$29,100 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	20% Coinsurance per visit after INET plan Deductible is met 20% Coinsurance per online visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	50% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	20% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	20% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	20% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2	20% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Chiropractic Services **(up to 20 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	20% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	20% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	50% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	20% Coinsurance per visit after INET plan Deductible is met	20% Coinsurance per visit after INET plan Deductible is met
Emergency Room	20% Coinsurance per visit after INET plan Deductible is met	20% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met

Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met0	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Anthem Gold PPO Century Preferred 1500/4500 for HSA
86545CT1340012_00_NSTD_Gold_PPO_1/17_ENG 2J6D

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, the entire Family Annual Deductible must be met before any Member of the family can receive benefits that are subject to the Deductible.		

Plan Deductible		
Individual	$1,500 per Member	$4,500 per Member
family	$4,500 per family	$13,500 per family
Out-of-Pocket Maximum		
Individual	$3,500 per Member	$10,500 per Member
family	$7,000 per family	$21,000 per family
(Includes Deductibles, Copayments and Coinsurance)		
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	20% Coinsurance per visit after INET plan Deductible is met 20% Coinsurance per online visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	50% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	20% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	20% Coinsurance per prescription after INET plan Deductible is met	50% Coinsurance per prescription after OON plan Deductible is met

Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	20% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 2	20% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		

Chiropractic Services **(up to 20 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	20% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	20% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	25% Coinsurance per visit after OON plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	50% Coinsurance per stay after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	20% Coinsurance per visit after INET plan Deductible is met	20% Coinsurance per visit after INET plan Deductible is met
Emergency Room	20% Coinsurance per visit after INET plan Deductible is met	20% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	20% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met

Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	20% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Anthem Gold PPO Century Preferred 1900/0%
86545CT1340013_00_NSTD_Gold_PPO_1/17_ENG 2J6E

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$1,900 per Member	$5,700 per Member
family	$5,700 per family	$17,100 per family
Out-of-Pocket Maximum **Individual**	$6,500 per Member	$19,500 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$13,000 per family	$39,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$30 Copayment per visit $15 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	$50 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; **$**400 for PET scans.	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service	50% Coinsurance per service after OON plan Deductible is met

Mammography Ultrasound	$20 Copayment per service	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met

Tier 2	$30 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$75 Copayment per prescription	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met

Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	$45 copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	30% Coinsurance per equipment or supply	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	30% Coinsurance per DME item	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per day to a maximum of $1,000 per Admission after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	$0 Copayment per visit after INET plan Deductible is met	$0 Copayment per visit after INET plan Deductible is met
Emergency Room	$150 Copayment per visit	$150 Copayment per visit
Urgent Care Centers	$75 Copayment per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after	50% Coinsurance per visit

	INET plan Deductible is met	after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit after INET plan Deductible is met	30% Coinsurance after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X, a Multi-State Plan
86545CT1480002_01_NSTD_Silver_PPO_1/17_ENG 2J73

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$3,500 per Member	$10,500 per Member
family	$10,500 per family	$31,500 per family
Out-of-Pocket Maximum **Individual**	$6,000 per Member	$18,000 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$12,000 per family	$36,000 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits $25 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$60 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met

Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$150 Copayment per prescription	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is

		met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after	50% Coinsurance per visit

	INET plan Deductible is met	after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X, a Multi-State Plan ZCSR
86545CT1480002_02_NSTD_Silver_PPO_1/17_ENG 2ER1

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$0 per Member	$0 per Member
family	$0 per family	$0 per family
Out-of-Pocket Maximum **Individual**	$0 per Member	$0 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$0 per family	$0 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	No Cost
Infant/Pediatric Preventive Visit	No Cost	No Cost

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost	No Cost
Specialist Office Visits	No Cost	No Cost
Mental Health and Substance Abuse Office Visit	No Cost	No Cost
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	No Cost	No Cost
Laboratory Services	No Cost	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost	No Cost

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	No Cost	No Cost
Tier 2	No Cost	No Cost
Tier 3	No Cost	No Cost
Tier 4	No Cost	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	No Cost	Not Covered
Tier 2	No Cost	Not Covered
Tier 3	No Cost	Not Covered
Tier 4	No Cost	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost	No Cost
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost	No Cost
Diabetic Equipment and Supplies	No Cost	No Cost
Durable Medical Equipment (DME)	No Cost	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost	No Cost
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	No Cost	No Cost

Emergency and Urgent Care		
Ambulance Services	No Cost	No Cost
Emergency Room	No Cost	No Cost

Urgent Care Centers	No Cost	No Cost
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	No Cost	No Cost
Major Services	No Cost	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost	No Cost
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X, a Multi-State Plan LCSR
86545CT1480002_03_NSTD_Silver_PPO_1/17_ENG 2ER0

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$3,500 per Member	$9,600 per Member
family	$10,500 per family	$19,200 per family
Out-of-Pocket Maximum **Individual**	$6,000 per Member	$15,300 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$12,000 per family	$30,600 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits $25 Copayment per online visit No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Laboratory Services	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per service after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	$60 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per prescription after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 2	$150 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	Not Covered
Outpatient Rehabilitative and Habilitative Services		

Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per equipment or supply after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per DME item after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider	25% Coinsurance per visit after $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service

		Provider
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	$200 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	$200 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost No Member cost when services	No Cost No Member cost when

	are rendered by an Indian Health Service Provider	services are rendered by an Indian Health Service Provider
Basic Services	40% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	40% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	50% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance after OON plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider	50% Coinsurance per visit after OON plan Deductible is met No Member cost when services are rendered by an

		Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem

Individual Market

Silver PPO Pathway X, a Multi-State Plan 73% CSR
86545CT1480002_04_NSTD_Silver_PPO_1/17_ENG 2J74

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$2,900 per Member	$9,600 per Member
family	$5,800 per family	$19,200 per family
Out-of-Pocket Maximum **Individual**	$5,500 per Member	$15,300 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$11,000 per family	$30,600 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$30 Copayment per visit Deductible is waived for first 3 visits $20 Copayment per online visit	50% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$30 Copayment per visit Deductible is waived for first 3 visits	50% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$55 Copayment per prescription	50% Coinsurance per prescription after OON plan Deductible is met

Tier 3	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier 4	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$137.50 Copayment per prescription	Not Covered
Tier 3	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	40% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is

		met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met	50% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after	50% Coinsurance per visit

	INET plan Deductible is met	after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X, a Multi-State Plan 87% CSR
86545CT1480002_05_NSTD_Silver_PPO_1/17_ENG 2EQY

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$1,000 per Member	$9,600 per Member
family	$2,000 per family	$19,200 per family
Out-of-Pocket Maximum **Individual**	$1,500 per Member	$15,300 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$3,000 per family	$30,600 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	30% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	30% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$20 Copayment per visit Deductible is waived for first 3 visits $15 Copayment per online visit	30% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$20 Copayment per visit Deductible is waived for first 3 visits	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	0% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$35 Copayment per prescription	30% Coinsurance per prescription after OON plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	30% Coinsurance per prescription after OON plan Deductible is met

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	30% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$87.50 Copayment per prescription	Not Covered
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	30% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is	30% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$250 Copayment per Admission after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$100 Copayment per visit after INET plan Deductible is met	$100 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem

Individual Market

Silver PPO Pathway X, a Multi-State Plan 94% CSR
86545CT1480002_06_NSTD_Silver_PPO_1/17_ENG 2EQZ

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$300 per Member	$9,600 per Member
family	$600 per family	$19,200 per family
Out-of-Pocket Maximum **Individual**	$600 per Member	$15,300 per Member
family **(Includes Deductibles, Copayments and Coinsurance)**	$1,200 per family	$30,600 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	30% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	30% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$15 Copayment per visit Deductible is waived for first 3 visits $10 Copayment per online visit	30% Coinsurance per visit after OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$15 Copayment per visit Deductible is waived for first 3 visits	30% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	30% Coinsurance per service after OON plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30 day supply per prescription)**		
Tier 1	$5 Copayment per prescription	30% Coinsurance per prescription after OON plan Deductible is met
Tier 2	$35 Copayment per prescription	30% Coinsurance per prescription after OON plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	30% Coinsurance per prescription after OON plan Deductible is met

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	30% Coinsurance per prescription after OON plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**		
Tier 1	$10 Copayment per prescription	Not Covered
Tier 2	$87.50 Copayment per prescription	Not Covered
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	30% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is	30% Coinsurance per DME item after OON plan

	met	Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(skilled nursing facility stay is limited to 90 days per Calendar Year)**	$150 Copayment per Admission after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$75 Copayment per visit after INET plan Deductible is met	$75 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$25 Copayment per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after INET plan Deductible is met	40% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for children under age 19).		

Prescription Eye Glasses **(one pair of frames and lenses or contact lens per year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	50% Coinsurance after OON plan Deductible is met
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met	30% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Bronze HMO Pathway X Enhanced 6250/12500/0% for HSA
86545CT1230001_00_NSTD_Bronze_HMO_1/17_ENG 1GVL

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $6,250 per Member $12,500 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $6,550 per Member $13,100 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	0% Coinsurance per visit after INET plan Deductible is met 0% Coinsurance per online visit after INET plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	

Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*)	$200 Copayment per Admission after INET plan Deductible is met

***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$150 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance Per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Bronze HMO Pathway X Enhanced for HSA
86545CT1230001_01_NSTD_Bronze_HMO_1/17_ENG 1GUQ

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $6,250 per Member $12,500 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $6,550 per Member $13,100 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	0% Coinsurance per visit after INET plan Deductible is met 0% Coinsurance per online visit after INET plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	

Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*)	$200 Copayment per Admission after INET plan Deductible is met

***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$150 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance Per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Bronze HMO Pathway X Enhanced for HSA ZCSR
86545CT1230001_02_NSTD_Bronze_HMO_1/17_ENG 1GVT

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $0 per Member $0 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $0 per Member $0 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost
Specialist Office Visits	No Cost
Mental Health and Substance Abuse Office Visit	No Cost
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	No Cost
Laboratory Services	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	No Cost
Tier 2	No Cost
Tier 3	No Cost
Tier 4	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	No Cost
Tier 2	No Cost
Tier 3	No Cost
Tier 4	No Cost
Outpatient Rehabilitative and	

Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost
Diabetic Equipment and Supplies	No Cost
Durable Medical Equipment (DME)	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	No Cost
Emergency and Urgent Care	
Ambulance Services	No Cost
Emergency Room	No Cost
Urgent Care Centers	No Cost
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	No Cost

Basic Services	No Cost
Major Services	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans

and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Bronze HMO Pathway X Enhanced for HSA LCSR
86545CT1230001_03_NSTD_Bronze_HMO_1/17_ENG 1YD5

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $6,250 per Member $12,500 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $6,550 per Member $13,100 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	0% Coinsurance per visit after INET plan Deductible is met 0% Coinsurance per online visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	

Tier 1	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)	
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$200 Copayment per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Emergency Room	$150 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance Per visit No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$0 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem
Individual Market

Anthem Bronze HMO Pathway X Enhanced 5800/0%
86545CT1230002_00_NSTD_Bronze_HMO_1/17_ENG 1GVM

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $5,800 per Member $11,600 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met $25 Copayment per online visit
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans.
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met

Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met

Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$75 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance Per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.

Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Bronze HMO Pathway X Enhanced
86545CT1230002_01_NSTD_Bronze_HMO_1/17_ENG 1GUR

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $5,800 per Member $11,600 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met $25 Copayment per online visit
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans.
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met

Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met

Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$75 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance Per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.

Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Bronze HMO Pathway X Enhanced ZCSR
86545CT1230002_02_NSTD_Bronze_HMO_1/17_ENG 1GVU

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $0 per Member $0 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $0 per Member $0 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost
Specialist Office Visits	No Cost
Mental Health and Substance Abuse Office Visit	No Cost
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	No Cost
Laboratory Services	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	No Cost
Tier 2	No Cost
Tier 3	No Cost
Tier 4	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	No Cost
Tier 2	No Cost
Tier 3	No Cost
Tier 4	No Cost
Outpatient Rehabilitative and	

Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost
Diabetic Equipment and Supplies	No Cost
Durable Medical Equipment (DME)	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	No Cost
Emergency and Urgent Care	
Ambulance Services	No Cost
Emergency Room	No Cost
Urgent Care Centers	No Cost
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	No Cost

Basic Services	No Cost
Major Services	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans

and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Bronze HMO Pathway X Enhanced LCSR
86545CT1230002_03_NSTD_Bronze_HMO_1/17_ENG 1YD6

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $5,800 per Member $11,600 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met $25 Copayment per online visit No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans. No Member cost when services are rendered by an Indian Health Service Provider
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

	No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy (30-day supply per prescription)	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy (90 day supply per prescription)	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	$200 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$75 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance Per visit No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met

	Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$0 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem
Individual Market

Anthem Gold HMO Pathway X Enhanced 1500/0%
86545CT1230004_00_NSTD_Gold_HMO_1/17_ENG 1GVR

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $1,500 per Member $4,500 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $4,800 per Member $9,600 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit $25 Copayment per online visit
Specialist Office Visits	$50 Copayment per visit
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans.
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	$5 Copayment per prescription
Tier 2	$60 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	

Tier 1	$10 Copayment per prescription
Tier 2	$150 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met

Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Gold HMO Pathway X Enhanced
86545CT1230004_01_NSTD_Gold_HMO_1/17_ENG 1GV5

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $1,500 per Member $4,500 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $4,800 per Member $9,600 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit $25 Copayment per online visit
Specialist Office Visits	$50 Copayment per visit
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans.
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	$5 Copayment per prescription
Tier 2	$60 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	

Tier 1	$10 Copayment per prescription
Tier 2	$150 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met

Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Gold HMO Pathway X Enhanced ZCSR
86545CT1230004_02_NSTD_Gold_HMO_1/17_ENG 1GVZ

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $0 per Member $0 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $0 per Member $0 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost
Specialist Office Visits	No Cost
Mental Health and Substance Abuse Office Visit	No Cost
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	No Cost
Laboratory Services	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	No Cost
Tier 2	No Cost
Tier 3	No Cost
Tier 4	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	No Cost
Tier 2	No Cost
Tier 3	No Cost
Tier 4	No Cost
Outpatient Rehabilitative and	

Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost
Diabetic Equipment and Supplies	No Cost
Durable Medical Equipment (DME)	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	No Cost
Emergency and Urgent Care	
Ambulance Services	No Cost
Emergency Room	No Cost
Urgent Care Centers	No Cost
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	No Cost

Basic Services	No Cost
Major Services	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans

and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Gold HMO Pathway X Enhanced LCSR
86545CT1230004_03_NSTD_Gold_HMO_1/17_ENG 1YDB

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $1,500 per Member $4,500 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $4,800 per Member $9,600 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit $25 Copayment per online visit No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans. No Member cost when services are rendered by an Indian Health Service Provider
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	

Tier 1	$5 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	$60 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	$10 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	$150 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

occupational therapies.)	
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	$200 Copayment per visit after INET plan Deductible is met

	No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.

Anthem
Individual Market

Anthem HMO Catastrophic Pathway X Enhanced 7150/0%
86545CT1230005_00_CAT_HMO_1/17_ENG 1JS2

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $7,150 per Member $14,300 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met $25 Copayment per online visit
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Services	0% Coinsurance per visit after INET plan Deductible is met

(in a hospital or ambulatory facility)	
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	0% Coinsurance per stay after INET plan Deductible is met
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	0% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Catastrophic HMO Pathway X Enhanced
86545CT1230005_01_CAT_HMO_1/17_ENG 1GV7

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $7,150 per Member $14,300 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met $25 Copayment per online visit
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Services	0% Coinsurance per visit after INET plan Deductible is met

(in a hospital or ambulatory facility)	
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	0% Coinsurance per stay after INET plan Deductible is met
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	0% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$0 Copayment per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Bronze HMO BlueCare 6200/12400/0% for HSA
86545CT1310019_00_NSTD_Bronze_HMO_1/17_ENG 1GVA

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $6,200 per Member $12,400 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $6,550 per Member $13,100 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	0% Coinsurance per visit after INET plan Deductible is met 0% Coinsurance per online visit after INET plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	

Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*)	$350 Copayment per Admission after INET plan Deductible is met

***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance Per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Silver HMO BlueCare 3500/7000/0% for HSA
86545CT1310030_00_NSTD_Silver_HMO_1/17_ENG 1GVE

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $3,500 per Member $7,000 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $4,000 per Member $8,000 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	0% Coinsurance per visit after INET plan Deductible is met 0% Coinsurance per online visit after INET plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	

Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*)	$500 Copayment per Admission after INET plan Deductible is met

***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Silver HMO BlueCare 3850/0%
86545CT1310031_00_NSTD_Silver_HMO_1/17_ENG 1GVF

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $3,850 per Member $11,550 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit $25 Copayment per online visit
Specialist Office Visits	$50 Copayment per visit
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans.
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	$5 Copayment per prescription
Tier 2	$60 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	

Tier 1	$10 Copayment per prescription
Tier 2	$150 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit
Diabetic Equipment and Supplies	30% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	30% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met

Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Gold HMO BlueCare 1500/0%
86545CT1310032_00_NSTD_Gold_HMO_1/17_ENG 1GVJ

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $1,500 per Member $4,500 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $4,800 per Member $9,600 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit $25 Copayment per online visit
Specialist Office Visits	$50 Copayment per visit
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans.
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	$5 Copayment per prescription
Tier 2	$60 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	

Tier 1	$10 Copayment per prescription
Tier 2	$150 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit
Diabetic Equipment and Supplies	20% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	20% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met

Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem HMO Catastrophic BlueCare 7150/0%
86545CT1310033_00_CAT_HMO_1/17_ENG 1GV8

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $7,150 per Member $14,300 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $7,150 per Member $14,300 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met $25 Copayment per online visit
Specialist Office Visits	0% Coinsurance per visit after INET plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after INET plan Deductible is met
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met

Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	0% Coinsurance per prescription after INET plan Deductible is met
Tier 2	0% Coinsurance per prescription after INET plan Deductible is met
Tier 3	0% Coinsurance per prescription after INET plan Deductible is met
Tier 4	0% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met
Outpatient Services	0% Coinsurance per visit after INET plan Deductible is met

(in a hospital or ambulatory facility)	
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	0% Coinsurance per stay after INET plan Deductible is met
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	0% Coinsurance per visit after INET plan Deductible is met
Urgent Care Centers	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit after INET plan Deductible is met
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 after INET plan Deductible is met Collection Frame: $0 after INET plan Deductible is met Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	0% Coinsurance per visit after INET plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Gold HMO BlueCare Tiered 1650/3300/0%
86545CT1310041_00_NSTD_Gold_HMO_1/17_ENG 2ERH

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	

	Value Tier 1 In-Network Member Pays	Participating Tier 2 In-Network Member Pays
Plan Deductible		
Individual	$1,650 per Member	$3,300 per Member
family	$3,300 per family	$6,600 per family
Out-of-Pocket Maximum		
Individual	$6,000 per Member	$6,000 per Member
family	$12,000 per Family	$12,000 per family
(Includes Deductible, Copayments and Coinsurance)		

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost

Infant/Pediatric Preventive Visit	No Cost	
	Value Tier 1 **In-Network** **Member Pays**	**Participating Tier 2** **In-Network** **Member Pays**
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$25 Copayment per visit $15 Copayment per online visit	$35 Copayment per visit $25 Copayment per online visit
Specialist Office Visits	$45 Copayment per visit	
	Value Tier 1 **In-Network** **Member Pays**	**Participating Tier2** **In-Network** **Member Pays**
Mental Health and Substance Abuse Office Visit	$25 Copayment per visit	$35 Copayment per visit
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans.	
Laboratory Services	$10 Copayment per service	
Non-Advanced Radiology (X-ray, Diagnostic)	$30 Copayment per service	
Mammography Ultrasound	$20 Copayment per service	

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	$5 Copayment per prescription
Tier 2	$60 Copayment per prescription
Tier 3	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription
Tier 4	40% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	$10 Copayment per prescription
Tier 2	$150 Copayment per prescription
Tier 3	40% Coinsurance per prescription after INET plan Deductible is met
Tier 4	40% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$20 Copayment per visit
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$20 Copayment per visit
Other Services	

Chiropractic Services **(up to 20 visits per Calendar Year)**	$45 Copayment per visit
Diabetic Equipment and Supplies	30% Coinsurance per equipment or supply
Durable Medical Equipment (DME)	30% Coinsurance per DME item
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$300 Copayment per visit after INET plan Deductible is met

Inpatient Hospital Services		
	Value Tier 1 **In-Network** **Member Pays**	**Participating Tier 2** **In-Network** **Member Pays**
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$250 Copayment per Admission after INET plan Deductible is met	$400 Copayment per day to a maximum $1,200 per Admission after INET plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met	
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	0% Coinsurance per visit	
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	
Major Services	0% Coinsurance per visit after INET plan Deductible is met	
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	
Pediatric Vision Care (for children under		

age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$45 Copayment per visit

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to

us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Anthem Silver HMO BlueCare Tiered 3550/6400/0%
86545CT1310042_00_NSTD_Silver_HMO_1/17_ENG 2ERJ

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	

	Value Tier 1 **In-Network** **Member Pays**	**Participating Tier 2** **In-Network** **Member Pays**
Plan Deductible **Individual**	$3,550 per Member	$6,400 per Member
family	$7,100 per family	$12,800 per family
Out-of-Pocket Maximum **Individual**	$7,150 per Member	$7,150 per Member
family **(Includes Deductible, Copayments and Coinsurance)**	$14,300 per Family	$14,300 per family

Benefits	**In-Network (INET)** **Member Pays**
Provider Office Visits	
Adult Preventive Visit	No Cost

Infant/Pediatric Preventive Visit	No Cost	
	Value Tier 1 **In-Network** **Member Pays**	**Participating Tier 2** **In-Network** **Member Pays**
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$30 Copayment per visit $20 Copayment per online visit	$40 Copayment per visit $25 Copayment per online visit
Specialist Office Visits	$50 Copayment per visit	
	Value Tier 1 **In-Network** **Member Pays**	**Participating Tier2** **In-Network** **Member Pays**
Mental Health and Substance Abuse Office Visit	$30 Copayment per visit	$40 Copayment per visit
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	$75 Copayment per service after INET plan Deductible is met Up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans.	
Laboratory Services	$10 Copayment per service after INET plan Deductible is met	
Non-Advanced Radiology (X-ray, Diagnostic)	$40 Copayment per service after INET plan Deductible is met	
Mammography Ultrasound	$20 Copayment per service after INET plan Deductible is met	

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	$5 Copayment per prescription
Tier 2	$60 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	$10 Copayment per prescription
Tier 2	$150 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	$30 Copayment per visit
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	$30 Copayment per visit
Other Services	

Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit
Diabetic Equipment and Supplies	40% Coinsurance per equipment or supply
Durable Medical Equipment (DME)	40% Coinsurance per DME item
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	$500 Copayment per visit after INET plan Deductible is met

Inpatient Hospital Services		
	Value Tier 1 **In-Network** **Member Pays**	**Participating Tier 2** **In-Network** **Member Pays**
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$400 Copayment per Admission after INET plan Deductible is met	$500 Copayment per day to a maximum $1,500 per Admission after INET plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	$200 Copayment per visit after INET plan Deductible is met	
Emergency Room	$200 Copayment per visit after INET plan Deductible is met	
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met	
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	0% Coinsurance per visit	
Basic Services	0% Coinsurance per visit after INET plan Deductible is met	
Major Services	0% Coinsurance per visit after INET plan Deductible is met	
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met	
Pediatric Vision Care (for children under		

age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to

us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Gold HMO Pathway X Enhanced, a Multi-State Plan
86545CT1470002_01_NSTD_Gold_HMO_1/17_ENG 1GV6

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $1,850 per Member $5,550 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $6,000 per Member $12,000 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$30 Copayment per visit $20 Copayment per online visit
Specialist Office Visits	$50 Copayment per visit
Mental Health and Substance Abuse Office Visit	$30 Copayment per visit
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	$5 Copayment per prescription
Tier 2	$60 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	$10 Copayment per prescription

Tier 2	$150 Copayment per prescription
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	0% Coinsurance per visit after INET plan Deductible is met
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met
Emergency and Urgent Care	

Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met
Emergency Room	$200 Copayment per visit after INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after INET plan Deductible is met
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit
Basic Services	0% Coinsurance per visit after INET plan Deductible is met
Major Services	0% Coinsurance per visit after INET plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Gold HMO Pathway X Enhanced, a Multi-State Plan ZCSR
86545CT1470002_02_NSTD_Gold_HMO_1/17_ENG 1GW0

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $0 per Member $0 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $0 per Member $0 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	No Cost
Specialist Office Visits	No Cost
Mental Health and Substance Abuse Office Visit	No Cost
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	No Cost
Laboratory Services	No Cost
Non-Advanced Radiology (X-ray, Diagnostic)	No Cost

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	No Cost
Tier 2	No Cost
Tier 3	No Cost
Tier 4	No Cost
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	No Cost
Tier 2	No Cost
Tier 3	No Cost
Tier 4	No Cost
Outpatient Rehabilitative and	

Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	No Cost
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)**	No Cost
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	No Cost
Diabetic Equipment and Supplies	No Cost
Durable Medical Equipment (DME)	No Cost
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost
Outpatient Services **(in a hospital or ambulatory facility)**	No Cost
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	No Cost
Emergency and Urgent Care	
Ambulance Services	No Cost
Emergency Room	No Cost
Urgent Care Centers	No Cost
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	No Cost

Basic Services	No Cost
Major Services	No Cost
Orthodontia Services **(Medically Necessary only)**	No Cost
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	No Cost

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the "What is Covered" section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans

and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try “Find a Doctor” on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision’s Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Anthem
Individual Market

Gold HMO Pathway X Enhanced, a Multi-State Plan LCSR
86545CT1470002_03_NSTD_Gold_HMO_1/17_ENG 1YDC

Schedule of Benefits

Deductible and Out-of-Pocket Maximum	**In-Network (INET)** **Member Pays**
Deductible - The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more eligible Dependents. If you have family coverage, each covered family Member needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving benefits that are subject to the Deductible	
Plan Deductible **Individual** **family**	 $1,850 per Member $5,550 per family
Out-of-Pocket Maximum **Individual** **family** **(Includes Deductible, Copayments and Coinsurance)**	 $6,000 per Member $12,000 per Family

Benefits	In-Network (INET) Member Pays
Provider Office Visits	
Adult Preventive Visit	No Cost
Infant/Pediatric Preventive Visit	No Cost
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$30 Copayment per visit $20 Copayment per online visit No Member cost when services are rendered by an Indian Health Service Provider
Specialist Office Visits	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider
Mental Health and Substance Abuse Office Visit	$30 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider

Prescription Drugs-Retail Pharmacy **(30-day supply per prescription)**	
Tier 1	$5 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider

Tier 2	$60 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription No Member cost when services are rendered by an Indian Health Service Provider
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription)**	
Tier 1	$10 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 2	$150 Copayment per prescription No Member cost when services are rendered by an Indian Health Service Provider
Tier 3	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Tier 4	50% Coinsurance per prescription after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Rehabilitative and Habilitative Services	
Speech Therapy **(40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies.)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Physical and Occupational Therapy **(40 visits per Calendar Year limit combined**	0% Coinsurance per visit after INET plan Deductible is met

for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies.)	No Member cost when services are rendered by an Indian Health Service Provider
Other Services	
Chiropractic Services **(up to 20 visits per Calendar Year)**	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Durable Medical Equipment (DME)	0% Coinsurance per DME item after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Home Health Care Services **(up to 100 visits per Calendar Year)**	0% Coinsurance per visit After $50 Home Health Care annual Deductible No Member cost when services are rendered by an Indian Health Service Provider
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Inpatient Hospital Services	
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) ***(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency and Urgent Care	
Ambulance Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Emergency Room	$200 Copayment per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Urgent Care Centers	$50 Copayment per visit after INET plan

	Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	0% Coinsurance per visit No Member cost when services are rendered by an Indian Health Service Provider
Basic Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Major Services	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Orthodontia Services **(Medically Necessary only)**	0% Coinsurance per visit after INET plan Deductible is met No Member cost when services are rendered by an Indian Health Service Provider
Pediatric Vision Care (for children under age 19).	
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. No Member cost when services are rendered by an Indian Health Service Provider
Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$50 Copayment per visit No Member cost when services are rendered by an Indian Health Service Provider

Important Notices about Your Benefits and Cost-Shares

Covered Dental Services pediatric dental services are covered for Members until the end of the month in which they turn 19. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Hearing aid coverage available one per ear every 24 months.

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabiliative service.

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30 day supply for retail and mail order.

Unrelated Donor Searches when approved by Anthem, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure up to $30,000.

Pediatric Vision benefits are covered for Members to the end of the month in which they turn age 19. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on our website or call the number on your ID card.

Pediatric Vision: Collection Contact Lenses You may use your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the Pediatric Vision Care section of your Schedule of Benefits for Cost-Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Eligible American Indians, as determined by the Exchange, enrolled in the Limited Cost Share Reduction plans, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no member responsibility for American Indians when Covered Services are rendered by one of these providers.