

	<b>Anthem Gold Priority Select HMO 35/1250/20% (6RG0) HMO / Gold</b>	<b>Anthem Gold Priority Select HMO 35/500/20% (6RGQ) HMO / Gold</b>
	<b>HMO</b>	<b>HMO</b>
<b>DEDUCTIBLE</b>		
Individual	\$1,250	\$500
Family	\$2,500 (embedded)	\$1,500 (embedded)
<b>OUT-OF-POCKET MAX</b>		
Individual	\$8,600 (includes ded)	\$8,450 (includes ded)
Family	\$17,200 (embedded; includes ded)	\$16,900 (embedded; includes ded)
<b>PHYSICIAN SERVICES</b>		
Office Visits	\$35/\$60 (ded waived)	\$35/\$55 (ded waived)
Telemedicine	Virtual Care: 0% (ded waived)	Virtual Care: 0% (ded waived)
Preventive Care	0% (ded waived)	0% (ded waived)
Diagnostic Lab/X-Ray	Office: \$15 (ded waived); Freestanding: 0% (ded waived)/ \$15 (ded waived); OPHosp: 20% after ded	Office: \$15 (ded waived); Freestanding: 0% (ded waived)/ \$15 (ded waived); OPHosp: 20% after ded
Imaging (CT/PET scans, MRIs)	Office/Freestanding: \$200 (ded waived); OPHosp: \$350 after ded	Office/Freestanding: \$200 (ded waived); OPHosp: \$350 after ded
Rehabilitation/Habilitation (PT/OT/ST)	\$35 (ded waived)	\$35 (ded waived)
Chiropractic Care	\$15 (ded waived; 30 visits per year)	\$15 (ded waived; 30 visits per year)
<b>PRESCRIPTION DRUGS</b>		
Pharmacy Deductible	None	None
Tier 1 (Generic Formulary)	Level 1: \$10; Level 2: \$20	Level 1: \$10; Level 2: \$20
Tier 2 (Preferred Brand Formulary)	Level 1: \$50; Level 2: \$60	Level 1: \$50; Level 2: \$60
Tier 3 (Non-Preferred Brand Formulary)	Level 1: \$90; Level 2: \$100	Level 1: \$90; Level 2: \$100
Tier 4 (Specialty Drugs)	Level 1: 30% up to \$250; Level 2: 40% up to \$250	Level 1: 30% up to \$250; Level 2: 40% up to \$250
Mail Order	Tier 1: 2.5x Retail; Tier 2-3: 3x Retail	Tier 1: 2.5x Retail; Tier 2-3: 3x Retail
<b>HOSPITAL FACILITY SERVICES</b>		
Inpatient Hospital Services	20% after ded	20% after ded
Outpatient Surgery in a Hospital	20% after ded	20% after ded
Ambulatory Surgical Center	\$500 after ded	\$500 after ded
<b>EMERGENCY SERVICES</b>		
Emergency Room	\$300 + 20% after ded (copay waived if admitted)	\$300 + 20% after ded (copay waived if admitted)
Emergency Transport/Ambulance	20% after ded	20% after ded
Urgent Care	\$35 (ded waived)	\$35 (ded waived)
<b>MENTAL HEALTH/SUBSTANCE USE DISORDER</b>		
Outpatient Services	\$35 (ded waived)	\$35 (ded waived)
Inpatient Services	20% after ded	20% after ded
<b>MATERNITY</b>		
Prenatal and Postnatal Care	Prenatal: 0% (ded waived); Postnatal: \$35 (ded waived)	Prenatal: 0% (ded waived); Postnatal: \$35 (ded waived)
Delivery and All Inpatient Services	20% after ded	20% after ded
<b>PEDIATRIC SERVICES (UP TO AGE 19)</b>		
Eye Exam	0% (ded waived; 1 visit per benefit period)	0% (ded waived; 1 visit per benefit period)
Glasses	0% (ded waived; 1 pair per benefit period)	0% (ded waived; 1 pair per benefit period)
Dental Check-up	0% after ded (1 visit every 6 months)	0% after ded (1 visit every 6 months)