

Plan benefit charts – HMO

HMO plans do not offer out of network benefits. Members will be responsible for all of the costs with some exceptions such as emergency services provided by out-of-network providers. If you see a doctor not in your plan for any other reason, you'll have to pay 100% out of pocket. The benefit information shown here is for in network services.

HMO plans are available in Fresno, Kings, Los Angeles (North), Los Angeles (South), Madera, Orange, Riverside, San Bernardino, and San Diego counties.

Plan type	Bronze plans	Silver plans	Gold plans
	HMO		
Plan name	Anthem Bronze 60 HMO (9KQ2)	Anthem Silver 70 HMO (9KQ0)	Anthem Gold 80 HMO (9KQU)
Network name	Pathway - HMO	Pathway - HMO	Pathway - HMO
Plan includes out of network coverage?	No	No	No
Individual deductible	\$6,300	\$5,400	\$0
Individual out-of-pocket maximum	\$9,100	\$9,100	\$8,700
Coinsurance (may vary for certain covered services)	40%	30%	20%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office and virtual visit: primary care physician (PCP) ^{2,3} (other office services may be subject to deductible and plan coinsurance)	\$60 copay per visit for first 3 visits, then deductible and \$60 copay	\$50 copay, deductible waived	\$35 copay
Primary and urgent care visits: virtual care-only providers ⁵	Covered in full, deductible waived	Covered in full, deductible waived	Covered in full
Office and online visit: specialist ³ (other office services may be subject to deductible and plan coinsurance)	\$95 copay per visit for first 3 visits, then deductible and \$95 copay	\$90 copay, deductible waived	\$65 copay
Outpatient diagnostic tests (ex. X-ray, EKG)	Deductible, then 40% coinsurance	\$95 copay, deductible waived	\$75 copay
Outpatient advanced diagnostic tests (ex. MRI, CT scan)	Deductible, then 40% coinsurance	\$325 copay, deductible waived	\$75 copay
Urgent care ³ (other office services may be subject to deductible and plan coinsurance)	\$60 copay per visit for first 3 visits, then deductible and \$60 copay	\$50 copay, deductible waived	\$35 copay
Emergency room care (copay, if applicable, waived if admitted into the hospital from the emergency room)	Deductible, then 40% coinsurance	\$450 copay, deductible waived	\$350 copay
Hospital: inpatient admission (includes maternity, mental health/substance use)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	\$330 copay per day up to 5 days per admission
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then 40% coinsurance	30% coinsurance, deductible waived	\$130 copay
Pharmacy deductible ⁴ (tiers with deductible, cost share applies after deductible)	Tiers 1,2,3,4: \$500 Combined pharmacy deductible	Tier 1: No deductible Tiers 2,3,4: \$150 Combined pharmacy deductible	Tiers 1,2,3,4: No deductible
Retail pharmacy tier 1	\$17 copay	\$19 copay	\$15 copay
Retail pharmacy tier 2	40% coinsurance (up to \$500 per script)	\$60 copay	\$60 copay
Retail pharmacy tier 3	40% coinsurance (up to \$500 per script)	\$90 copay	\$85 copay
Retail pharmacy tier 4	40% coinsurance (up to \$500 per script)	20% coinsurance (up to \$250 per script)	20% coinsurance (up to \$250 per script)
Physical and occupational therapy	\$60 copay, deductible waived	\$50 copay, deductible waived	\$35 copay
Speech therapy	\$60 copay, deductible waived	\$50 copay, deductible waived	\$35 copay

Please see Medical and Silver cost-share reduction plans footnotes on page 13.

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Plan type	Platinum plans	Catastrophic plans
	HMO	
Plan name	Anthem Platinum 90 HMO (9KQT)	Anthem Minimum Coverage HMO (9KPZ)
Network name	Pathway - HMO	Pathway - HMO
Plan includes out of network coverage?	No	No
Individual deductible	\$0	\$9,450
Individual out-of-pocket maximum	\$4,500	\$9,450
Coinsurance (may vary for certain covered services)	10%	0%
Preventive care ¹	No additional cost to you.	No additional cost to you.
Office and virtual visit: primary care physician (PCP) ^{2,3} (other office services may be subject to deductible and plan coinsurance)	\$15 copay	\$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Primary and urgent care visits: virtual care-only providers ⁵	Covered in full	\$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Office and online visit: specialist ³ (other office services may be subject to deductible and plan coinsurance)	\$30 copay	Deductible, then covered in full
Outpatient diagnostic tests (ex. X-ray, EKG)	\$30 copay	Deductible, then covered in full
Outpatient advanced diagnostic tests (ex. MRI, CT scan)	\$75 copay	Deductible, then covered in full
Urgent care ³ (other office services may be subject to deductible and plan coinsurance)	\$15 copay	\$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Emergency room care (copay, if applicable, waived if admitted into the hospital from the emergency room)	\$150 copay	Deductible, then covered in full
Hospital: inpatient admission (includes maternity, mental health/substance use)	\$225 copay per day up to 5 days per admission	Deductible, then covered in full
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	\$75 copay	Deductible, then covered in full
Pharmacy deductible ⁴ (tiers with deductible, cost share applies after deductible)	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: Medical deductible applies
Retail pharmacy tier 1	\$7 copay	0% coinsurance
Retail pharmacy tier 2	\$16 copay	0% coinsurance
Retail pharmacy tier 3	\$25 copay	0% coinsurance
Retail pharmacy tier 4	10% coinsurance (up to \$250 per script)	0% coinsurance
Physical and occupational therapy	\$15 copay	Deductible, then covered in full
Speech therapy	\$15 copay	Deductible, then covered in full

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