ANTHEM

Small Business Health Options Program (SHOP)

Gold Pathway X HMO

Schedule of Benefits

This is a brief schedule of benefits. Refer to your Anthem Certificate of Coverage (Booklet) for complete details on benefits, conditions, limitations and exclusions. All benefits described below are per member per Benefit Period. Each Member should pick a PCP for routine physicals and to help when you are ill or need follow-up care after you receive Emergency Services. A referral from your Primary Care Provider is not required.

Please see "Important Notices about Your Benefits and Cost-Shares" for important notices pertaining to your benefits, limits, or cost-shares.

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible *Individual* *Family*	 $2,750 per Member $5,500 per Family	Not Applicable
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)	 $4,000 per Member $8,000 per Family	Not Applicable
Provider Office Visits		
Adult Preventive Visit	No Cost-Share	Not Covered
Infant / Pediatric Preventive Visit	No Cost-Share	Not Covered
Primary Care Provider Office Visits (Includes services for illness, injury, follow-up care and consultations)	$25 Copayment per visit	Not Covered
Specialist Office Visits	$45 Copayment per visit,	Not Covered
Mental Health and Substance Abuse Office Visit	$25 Copayment per visit,	Not Covered

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Diagnostic Services		
Advanced Radiology (Including MRI, CAT, CT, PET Scans, MRI and other diagnostic services.)	$75 Copayment per service up to an annual maximum of $375 for MRI and CAT scans, and $400 for PET scans	Not Covered
Laboratory Services	No Cost-Share	Not Covered
Non-Advanced Radiology (Including X-ray, Breast Tomosynthesis, and other diagnostic services.)	$25 Copayment per service	Not Covered
Mammography Ultrasound	$20 Copayment per service	Not Covered
Prescription Drugs – Retail Pharmacy *(30 day supply per prescription)*		
Tier 1 Prescription Drugs	$5 Copayment per Prescription	Not Covered
Tier 2 Prescription Drugs	$50 Copayment per Prescription	Not Covered
Tier 3 Prescription Drugs	50% Coinsurance up to a maximum of $500 per Prescription	Not Covered
Tier 4 Prescription Drugs	50% Coinsurance up to a maximum of $500 per Prescription	Not Covered
Prescription Drugs – Mail Order Pharmacy (Home Delivery Pharmacy) *(90 day supply per prescription)*		
Tier 1 Prescription Drugs	$13 Copayment per Prescription	Not Covered
Tier 2 Prescription Drugs	$150 Copayment per Prescription	Not Covered
Tier 3 Prescription Drugs	50% Coinsurance up to a maximum of $1,500 per Prescription	Not Covered
Tier 4 Prescription Drugs	50% Coinsurance up to a maximum of 1,500 per Prescription	Not Covered

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Rehabilitative and Habilitative Services (Therapy Services)		
Speech Therapy (Up to 40 visits per plan year, limit combined for Rehabilitative physical, speech, and occupational therapy) (Up to a separate 40 visits per plan year, limit combined for Habilitative physical, speech, and occupational therapy)	$30 Copayment per visit,	Not Covered
Physical and Occupational Therapy (Up to 40 visits per plan year, limit combined for Rehabilitative physical, speech, and occupational therapy) (Up to a separate 40 visits per plan year, limit combined for Habilitative physical, speech, and occupational therapy)	$30 Copayment per visit,	Not Covered
Other Services		
Chiropractic Services (Up to 20 visits per plan year)	$45 Copayment per visit,	Not Covered
Diabetic Equipment and Supplies	50% Coinsurance	Not Covered
Durable Medical Equipment (DME)	50% Coinsurance	Not Covered
Home Health Care Services (Up to 100 visits per plan year)	$25 Copayment per visit	Not Covered
Outpatient Services • In a hospital based facility including an ambulatory facility • In a free-standing facility, not associated with a hospital	 $300 Copayment per visit after INET plan Deductible is met $200 Copayment per visit	 Not Covered Not Covered
Inpatient Services		
Inpatient Hospital Services (Including mental health, substance abuse, maternity, hospice, Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services, and skilled nursing facility) (Skilled nursing facility stay combined with inpatient rehabilitation is limited to 90 days per plan year)	$500 Copayment per day up to $2,000 per admission after INET plan Deductible is met	Not Covered

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Emergency and Urgent Care		
Ambulance Services	No Cost-Share	No Cost-Share
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,	Not Covered
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost-Share	Not Covered
Basic Restorative Services	No Cost-Share after INET plan Deductible is met	Not Covered
Major Restorative Services	No Cost-Share after INET plan Deductible is met	Not Covered
Orthodontia Services (Medically necessary only)	No Cost-Share after INET plan Deductible is met	Not Covered
Pediatric Vision Care (for children under age 19)		
Prescription Eye Glasses (One pair of frames and lenses per plan year)	**Lenses:** No Cost-Share **Collection frame:** No Cost-Share **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 a Specialist (One exam per plan year)	$45 Copayment per visit	Not Covered