ANTHEM

Small Business Health Options Program (SHOP)

Platinum Standard Pathway X PPO

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	$100 per Member	$2,000 per Member
Family	$200 per Family	$4,000 per Family
Out-of-Pocket Maximum		
Individual	$2,000 per Member	$4,000 per Member
Family	$4,000 per Family	$8,000 per Family
(Includes deductible, copayments and coinsurance)		
Provider Office Visits		
Adult Preventive Visit	No Cost-Share	20% Coinsurance
Infant / Pediatric Preventive Visit	No Cost-Share	20% Coinsurance
Primary Care Provider Office Visits (Includes services for illness, injury, follow-up care and consultations)	$15 Copayment per visit	20% Coinsurance after OON plan Deductible is met
Specialist Office Visits	$35 Copayment per visit	20% Coinsurance after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$15 Copayment per visit	20% Coinsurance after OON plan Deductible is met

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	20% Coinsurance after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	20% Coinsurance after OON plan Deductible is met
Non-Advanced Radiology (Including X-ray, Breast Tomosynthesis, and other diagnostic services)	$40 Copayment per service	20% Coinsurance after OON plan Deductible is met
Mammography Ultrasound	$20 Copayment per service	20% Coinsurance after OON plan Deductible is met
Prescription Drugs – Retail Pharmacy *(30 day supply per prescription)*		
Tier 1 Prescription Drugs	$5 Copayment per Prescription	20% Coinsurance after OON plan Deductible is met
Tier 2 Prescription Drugs	$25 Copayment per Prescription	20% Coinsurance after OON plan Deductible is met
Tier 3 Prescription Drugs	$40 Copayment per Prescription	20% Coinsurance after OON plan Deductible is met
Tier 4 Prescription Drugs	20% Coinsurance up to a maximum of $100 per Prescription	20% Coinsurance after OON plan Deductible is met
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	$75 Copayment per Prescription	Not Covered
Tier 3 Prescription Drugs	$120 Copayment per prescription	Not Covered
Tier 4 Prescription Drugs	20% Coinsurance up to a maximum of $300 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)	$15 Copayment per visit	20% Coinsurance after OON plan Deductible is met
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)	$15 Copayment per visit,	20% Coinsurance after OON plan Deductible is met
Other Services		
Chiropractic Services (Up to 20 visits per plan year)	$35 Copayment per visit,	20% Coinsurance after OON plan Deductible is met
Diabetic Equipment and Supplies	20% Coinsurance	20% Coinsurance after OON plan Deductible is met
Durable Medical Equipment (DME)	20% Coinsurance	20% Coinsurance after OON plan Deductible is met
Home Health Care Services (Up to 100 visits per plan year)	No Cost-Share	20% Coinsurance after $50 Deductible is met
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 $300 Copayment per visit after INET plan Deductible is met	 20% Coinsurance after OON plan Deductible is met 20% Coinsurance after OON plan Deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
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)	$300 Copayment per day up to $600 per admission after INET plan Deductible is met	20% Coinsurance after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost-Share	No Cost-Share
Emergency Room	$100 Copayment per visit	$100 Copayment per visit
Urgent Care Centers	$50 Copayment per visit,	20% Coinsurance after OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost-Share	50% Coinsurance after OON plan Deductible is met
Basic Restorative Services	20% Coinsurance	50% Coinsurance after OON plan Deductible is met
Major Restorative Services	40% Coinsurance	50% Coinsurance after OON plan Deductible is met
Orthodontia Services (Medically necessary only)	50% Coinsurance	50% Coinsurance after OON plan Deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
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)	$35 Copayment per visit	20% Coinsurance after OON plan Deductible is met