

**Anthem
Small Group Market
Platinum Pathway X PPO**

Schedule of Benefits

This is a brief "Schedule of Benefits" which generally describes the Plan's benefits for Covered Services, and the cost-share(s) you must pay, and where services are usually received. Generally your benefits and cost-shares are based on the setting in which Covered Services are received (e.g., in a doctor's office, at an outpatient hospital facility, etc.). Please see "Important Notices about Your Benefits and Cost-Shares" for additional information about how your Deductible and Out-of-Pocket works, and other important notices pertaining to your benefits, limits, or cost-shares.

Your Plan provides you with the option to lower your out-of-pocket costs for certain services by going to Site-of-Service Providers or Surgical Centers. These Providers may have lower cost-shares and Maximum Allowed Amounts, reducing your Out-of-Pocket costs for certain services. When you use the "Find a Doctor" tool on anthem.com look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort by Benefit Tier and show these providers first in your results.

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible	Not Applicable	
Individual		\$2,000 per Member
Family		\$4,000 per Family
Coinsurance After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	0% Coinsurance	30% Coinsurance
Out-of-Pocket Limit		
Individual	\$2,500 per Member	\$7,500 per Member
Family	\$5,000 per Family	\$15,000 per Family
Includes Deductibles, Copayments and Coinsurance		
Provider Office Visits		
Adult / Pediatric Preventive Visit	No Cost-Share	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Primary Care Provider Office Visits Includes services for illness, injury, follow-up care, telehealth, and consultations.	\$10 Copayment per visit	30% Coinsurance after Deductible is met
Online Visits	No Cost-Share when you visit Live Health Online \$10 Copayment per visit from other online Providers	30% Coinsurance after Deductible is met
Specialist Office Visits Includes telehealth, and consultations.	\$30 Copayment per visit	30% Coinsurance after Deductible is met
Mental Health and Substance Abuse Office Visit Including Office Visits, telehealth, Outpatient treatment, and in Home treatment.	\$10 Copayment per visit	30% Coinsurance after Deductible is met
Retail Health Clinic	\$10 Copayment per visit	30% Coinsurance after Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology Including MRI, CAT, CT, PET Scans, and other diagnostic services.	\$75 Copayment per service up to an annual maximum of \$375 for MRI, MRA, CAT, CTA, PET and SPECT scans at Site-of-Service Providers \$75 Copayment per service up to an annual maximum of \$375 for MRI, MRA, CAT, CTA, PET and SPECT scans at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	No Cost-Share at Site-of-Service Providers \$10 Copayment per service at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Non-Advanced Radiology Including x-ray, Breast Tomosynthesis, and other diagnostic services. Certain screenings may be covered under the "Preventive Care" benefit.	No Cost-Share at Site-of-Service Providers \$40 Copayment per service at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Prescription Drugs – Retail Pharmacy 30-day supply per Prescription Order at a Retail Pharmacy. Up to a 90-day supply is available at Maintenance Pharmacies for Tiers 1, 2, and 3. When you get a 90-day supply at Maintenance Pharmacy, three (3) Retail Pharmacy Copayments or Coinsurance maximums (one for each 30-day period) will apply. Copayment and Coinsurance maximum amounts shown below are based on a 30-day supply per Prescription Order.		
Tier 1 - Typically Generic Prescription Drugs	\$5 Copayment per Prescription Order	50% Coinsurance
Tier 2 – Typically Preferred Brand Prescription Drugs	\$50 Copayment per Prescription Order	50% Coinsurance
Tier 3 – Typically Non- Preferred Brand Prescription Drugs	30% Coinsurance to a Coinsurance maximum of \$500 per Prescription Order	50% Coinsurance
Tier 4 – Typically Specialty Prescription Drugs Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	30% Coinsurance to a Coinsurance maximum of \$1,000 per Prescription Order	50% Coinsurance
Prescription Drugs – Mail Order Pharmacy 90-day supply per Prescription Order for Tiers 1, 2, and 3, and a 30-day supply per Prescription Order for Tier 4.		
Tier 1 - Typically Generic Prescription Drugs	\$13 Copayment per Prescription Order	50% Coinsurance
Tier 2 – Typically Preferred Brand Prescription Drugs	\$150 Copayment per Prescription Order	50% Coinsurance

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	30% Coinsurance to a Coinsurance maximum of \$1,500 per Prescription Order	50% Coinsurance
Tier 4 – Typically Specialty Prescription Drugs Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	30% Coinsurance to a Coinsurance maximum of \$1,000 per Prescription Order	50% Coinsurance
Prescription Drugs – Administered by a Medical Providers Including Specialty Drugs and other drugs and serums for infusion or injection. Does not include Drugs provided while you are inpatient at a Facility.		
Medical Office	No Cost-Share	30% Coinsurance after Deductible is met
Urgent Facility	No Cost-Share	30% Coinsurance after Deductible is met
Outpatient Hospital	No Cost-Share	30% Coinsurance after Deductible is met
Home Health Agency	\$25 Copayment	25% Coinsurance after \$50 Deductible is met
Therapy Services (Outpatient Rehabilitative and Habilitative)		
Speech Therapy Up to 40 visits for Rehabilitative services and up to 40 visits for Habilitative services per plan year. Limits are combined for physical, speech, and occupational therapy.	\$30 Copayment per visit in an Office \$30 Copayment per visit at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Physical and Occupational Therapy Up to 40 visits for Rehabilitative services and up to 40 visits for Habilitative services per plan year. Limits are combined for physical, speech, and occupational therapy.	\$30 Copayment per visit in an Office \$30 Copayment per visit at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Other Services		
Chiropractic Care Up to 20 visits for manipulative treatment per plan year.	\$30 Copayment per visit in an Office \$30 Copayment per visit at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Diabetic Equipment and Supplies	50% Coinsurance	50% Coinsurance after Deductible is met
Durable Medical Equipment (DME)	50% Coinsurance	50% Coinsurance after Deductible is met
Home Health Care Services Up to 100 visits per plan year provided by a Home Health Care Agency.	\$25 Copayment per visit	25% Coinsurance after a \$50 Deductible is met
Allergy Testing	\$30 Copayment per visit	30% Coinsurance after Deductible is met
Allergy Treatment Injection, Immunotherapy, or other therapy treatments	\$30 Copayment per visit	30% Coinsurance after Deductible is met
Artificial Limbs Includes associated supplies and equipment	20% Coinsurance	50% Coinsurance after Deductible is met
Cardiac Rehab Therapy	\$30 Copayment per visit in an Office \$30 Copayment per visit at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Counseling Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders).	\$10 Copayment per visit	30% Coinsurance after Deductible is met
Dialysis and Hemodialysis	No Cost-Share in an Office No Cost-Share at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Home Dialysis and Infusion Therapy	No Cost-Share	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Nutritional Counseling for Eating Disorders	\$10 Copayment per visit	30% Coinsurance after Deductible is met
Other Therapy Services Including radiation, chemo, respiratory	No Cost-Share in an Office \$30 Copayment per visit at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Prosthetics	50% Coinsurance	50% Coinsurance after Deductible is met
Pulmonary	\$30 Copayment per visit in an Office \$30 Copayment per visit at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Facility Services		
Outpatient Services Including surgery, infertility, hospice, and diagnostic colonoscopy.	\$300 Copayment per visit at a Surgical Center \$400 Copayment per visit at an Outpatient Hospital Facility	30% Coinsurance after Deductible is met
Inpatient Hospital Acute Care Facility Including mental health, substance abuse, maternity, infertility, hospice, and Human Organ and Tissue Transplant Services.	\$500 Copayment per day up to \$1,000 per admission	30% Coinsurance after Deductible is met
Inpatient Rehabilitation Facility Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	\$500 Copayment per day up to \$1,000 per admission	30% Coinsurance after Deductible is met
Partial Hospitalization and Intensive Outpatient Services in a Facility For Mental Health and Substance Abuse treatment.	\$400 Copayment	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.	No Cost-Share at an Outpatient Hospital Facility No Cost-Share at an Inpatient Facility No Cost-Share at a Mental Health and Substance Abuse Inpatient Facility	30% Coinsurance after Deductible is met
Residential Treatment Center For Mental Health and Substance Abuse services.	\$500 Copayment per day up to \$1,000 per admission	30% Coinsurance after Deductible is met
Skilled Nursing Facility Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	\$500 Copayment per day up to \$1,000 per admission	30% Coinsurance after Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost-Share	No Cost-Share
Emergency Room	\$250 Copayment per visit	\$250 Copayment per visit
Urgent Care Services Urgent Care Services may be received in various settings, please refer to those sections of the Schedule for details on what you will pay.	\$10 Copayment per visit at a Walk-In Center \$100 Copayment per visit at an Urgent Care Facility (Urgent Care Center)	30% Coinsurance after Deductible is met
Pediatric Dental Care (For children under age 19)		
Diagnostic & Preventive 2 times per 12 month period	No Cost-Share	No Cost-Share
Basic Services	40% Coinsurance	40% Coinsurance after Deductible is met
Major Services Including Endodontic, Periodontal, Oral Surgery and Prosthodontic services.	50% Coinsurance	50% Coinsurance after Deductible is met
Orthodontia Services Medically necessary only	50% Coinsurance	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Pediatric Vision Care (For children under age 19)		
<p>Prescription Eye Glasses One pair of frames from the Anthem formulary and lenses or contact lens per plan year.</p> <p>Covered lenses include factory scratch coating, UV coating, Anti-Reflective coating, tints, Glass Grey #3, standard polycarbonate and standard photochromic lenses at no additional cost when received In-Network.</p>	<p>No Cost-Share for Single Vision, Bifocal, Trifocal, Lenticular, and standard Progressive Lenses</p> <p>No Cost-Share for Formulary frames</p>	50% Coinsurance
<p>Contact Lenses One set of contact lenses from the Anthem formulary every plan year. Available only if the eyeglass lenses benefit is not used.</p>	<p>No Cost-Share for Elective Contact Lenses</p> <p>No Cost-Share for Non-Elective Contact Lenses</p>	50% Coinsurance
<p>Routine Eye Exam by a Specialist One exam per plan year, limit is combined with Low Vision Exam.</p>	\$20 Copayment per visit	50% Coinsurance
<p>Low Vision Exam by a Specialist One exam per plan year, limit is combined with Routine Eye Exam.</p>	No Cost-Share	50% Coinsurance