# Anthem
# Small Group Market
# Gold Pathway CT 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. Typically 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 Ambulatory Surgical Facility (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 / Find Care" tool on anthem.com look for the "Site-of-Service (SOS)" indicator by the Provider's name. You can use the "Recognitions" sort function, at the top of the search, to only select "Site-of-Service" Providers.

| **Benefit** | In-Network (INET)<br>**Participating Providers**<br>Member Pays | **Out-of-Network (OON)**<br>Member Pays |
|---|---|---|
| **Plan Deductible** | | |
| **Individual** | $2,500 per Member | $7,500 per Member |
| **Family** | $5,000 per Family | $15,000 per Family |
| In-Network Deductible may not apply to all services. | | |
| **Coinsurance**<br>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** | $4,500 per Member | $13,500 per Member |
| **Family** | $9,000 per Family | $27,000 per Family |
| Includes Deductibles, Copayments and Coinsurance | | |
| **Provider Office Visits** | | |
| **Adult / Pediatric Preventive Visit** | No Copayment, Deductible, or Coinsurance | 30% Coinsurance after Deductible is met |

| Benefit | In-Network (INET)<br>**Participating Providers**<br>Member Pays | **Out-of-Network (OON)**<br>Member Pays |
|---|---|---|
| **Primary Care Provider Office Visits (PCP)**<br>Includes services for illness, injury, follow-up care, telehealth, and consultations | $25 Copayment per visit | 30% Coinsurance after Deductible is met |
| **Online Visits**<br>Includes Primary Care and Mental Health & Substance Abuse Services. | No Copayment, Deductible, or Coinsurance for the first 12 visits, then a $20 Copayment per visit applies<br>**When you visit Live Health Online**<br><br>$25 Copayment per visit<br>**from other online Providers** | 30% Coinsurance after Deductible is met |
| **Specialist Office Visits (SPC)**<br>Includes telehealth, Online visits, and consultations. | $50 Copayment per visit | 30% Coinsurance after Deductible is met |
| **Mental Health and Substance Abuse Office Visit**<br>Including Office Visits, telehealth, Outpatient treatment, and in Home treatment. | $25 Copayment per visit | 30% Coinsurance after Deductible is met |
| **Retail Health Clinic** | $25 Copayment per visit | 30% Coinsurance after Deductible is met |
| **Outpatient Diagnostic Services** | | |
| **Advanced Radiology**<br>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<br>**at Site-of-Service Providers**<br><br>No Copayment or Coinsurance after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance after Deductible is met |
| **Laboratory Services** | No Copayment, Deductible, or Coinsurance<br>**at Site-of-Service Providers**<br><br>No Copayment or Coinsurance after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance after Deductible is met |

| Benefit | In-Network (INET)<br>**Participating Providers**<br>Member Pays | **Out-of-Network (OON)**<br>Member Pays |
|---|---|---|
| **Non-Advanced Radiology**<br>Including x-ray, Breast Tomosynthesis, and other diagnostic services.<br><br>Certain screenings may be covered under the "Preventive Care" benefit. | No Copayment, Deductible, or Coinsurance<br>**at Site-of-Service Providers**<br><br>No Copayment or Coinsurance after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |
| **Prescription Drugs – Retail Pharmacy**<br>A 30-day supply per Prescription Drug or Prescription Drug refillat a Retail Pharmacy. Up to a 90-day supply is available at In-Network 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 Drug or Prescription Drug refill**. | | |
| **Tier 1 - Typically Generic Prescription Drugs** | $5 Copayment<br>per Prescription Drug | 50% Coinsurance |
| **Tier 2 – Typically Preferred Brand Prescription Drugs** | $50 Copayment<br>per Prescription Drug | 50% Coinsurance |
| **Tier 3 – Typically Non-Preferred Brand Prescription Drugs** | 30% Coinsurance<br>to a Coinsurance maximum of $500 per Prescription Drug | 50% Coinsurance |
| **Tier 4 – Typically Specialty Prescription Drugs**<br>Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply. | 30% Coinsurance<br>to a Coinsurance maximum of $1,000 per Prescription Drug | 50% Coinsurance |
| **Prescription Drugs – Home Delivery (Mail Order) Pharmacy**<br>A 90-day supply per Prescription Drug or Prescription Drug refill at an In-Network Pharmacy for Tiers 1, 2, and 3, and a 30-day supply per Prescription Drug or Prescription Drug refill for Tier 4. A 30-day supply per Prescription Drug or Prescription Drug refill at an Out-of-Network Pharmacy. | | |
| **Tier 1 - Typically Generic Prescription Drugs** | $13 Copayment<br>per Prescription Drug | 50% Coinsurance |
| **Tier 2 – Typically Preferred Brand Prescription Drugs** | $150 Copayment<br>per Prescription Drug | 50% Coinsurance |
| **Tier 3 – Typically Non-Preferred Brand Prescription Drugs** | 30% Coinsurance<br>to a Coinsurance maximum of $1,500 per Prescription Drug | 50% Coinsurance |
| **Tier 4 – Typically Specialty Prescription Drugs**<br>Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply. | 30% Coinsurance<br>to a Coinsurance maximum of $1,000 per Prescription Drug | 50% Coinsurance |

| **Benefit** | In-Network (INET)<br>**Participating Providers**<br>Member Pays | **Out-of-Network (OON)**<br>Member Pays |
|---|---|---|
| **Prescription Drugs – Administered by a Medical Providers**<br>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** | See PCP / SPC Copayment | 30% Coinsurance<br>after Deductible is met |
| **Urgent Facility** | No Copayment, Deductible, or Coinsurance | 30% Coinsurance<br>after Deductible is met |
| **Outpatient Hospital** | No Copayment or Coinsurance<br>after Deductible is met | 30% Coinsurance<br>after Deductible is met |
| **Home Health Agency** | 25% Coinsurance<br>after a $50 Deductible<br>is met | 25% Coinsurance<br>after a $50 Deductible<br>is met |
| **Therapy Services (Outpatient Rehabilitative and Habilitative)** | | |
| **Speech Therapy**<br>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<br>**in an Office**<br><br>No Copayment or Coinsurance<br>after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |
| **Physical and Occupational Therapy**<br>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<br>**in an Office**<br><br>No Copayment or Coinsurance<br>after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |
| **Other Services** | | |
| **Chiropractic Care**<br>Up to 20 visits for manipulative treatment per plan year. | $50 Copayment per visit<br>**in an Office**<br><br>No Copayment or Coinsurance<br>after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |
| **Diabetic Equipment and Supplies** | 50% Coinsurance<br>after Deductible is met | 50% Coinsurance<br>after Deductible is met |
| **Durable Medical Equipment (DME)** | 50% Coinsurance<br>after Deductible is met | 50% Coinsurance<br>after Deductible is met |

| **Benefit** | In-Network (INET)<br>**Participating Providers**<br>Member Pays | **Out-of-Network (OON)**<br>Member Pays |
|---|---|---|
| **Home Health Care Services**<br>Up to 100 visits per plan year provided by a Home Health Care Agency. | 25% Coinsurance<br>after $50 Deductible is met | 25% Coinsurance<br>after $50 Deductible is met |
| **Allergy Testing** | $50 Copayment per visit | 30% Coinsurance<br>after Deductible is met |
| **Allergy Treatment**<br>Injection, Immunotherapy, or other therapy treatments | $50 Copayment per visit | 30% Coinsurance<br>after Deductible is met |
| **Artificial Limbs**<br>Includes associated supplies and equipment | 20% Coinsurance<br>after Deductible is met | 30% Coinsurance<br>after Deductible is met |
| **Cardiac Rehabilitation Therapy** | $50 Copayment per visit<br>**in an Office**<br><br>No Copayment or Coinsurance after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |
| **Counseling**<br>Includes Family Planning and Nutritional Counseling (other than Eating Disorders). | $25 Copayment per visit | 30% Coinsurance<br>after Deductible is met |
| **Dialysis and Hemodialysis** | No Copayment, Deductible, or Coinsurance<br>**in an Office**<br><br>No Copayment or Coinsurance after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |
| **Home Dialysis and Infusion Therapy** | 25% Coinsurance<br>after Deductible is met | 30% Coinsurance<br>after Deductible is met |
| **Nutritional Counseling for Eating Disorders** | $25 Copayment per visit | 30% Coinsurance<br>after Deductible is met |
| **Other Therapy Services**<br>Including radiation, chemotherapy, respiratory therapy | No Copayment, Deductible, or Coinsurance**in an Office**<br><br>No Copayment or Coinsurance after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |

| **Benefit** | In-Network (INET)<br>**Participating Providers**<br>Member Pays | **Out-of-Network (OON)**<br>Member Pays |
|---|---|---|
| **Prosthetics** | 50% Coinsurance<br>after Deductible is met | 50% Coinsurance<br>after Deductible is met |
| **Pulmonary Therapy** | $50 Copayment per visit<br>**in an Office**<br><br>No Copayment or Coinsurance<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |
| **Facility Services** | | |
| **Outpatient Services**<br>Including surgery, infertility, hospice, and diagnostic colonoscopy. | $300 Copayment per visit<br>**at a Surgical Center**<br><br>No Copayment or Coinsurance<br>after Deductible is met<br>**at an Outpatient Hospital Facility** | 30% Coinsurance<br>after Deductible is met |
| **Inpatient Hospital Acute Care Facility**<br>Including mental health, substance abuse, maternity, infertility, hospice, and Human Organ and Tissue Transplant Services. | No Copayment or Coinsurance<br>after Deductible is met | 30% Coinsurance<br>after Deductible is met |
| **Inpatient Rehabilitation Facility**<br>Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation. | No Copayment or Coinsurance<br>after Deductible is met | 30% Coinsurance<br>after Deductible is met |
| **Partial Hospitalization and Intensive Outpatient Services in a Facility**<br>For Mental Health and Substance Abuse treatment. | No Copayment, Deductible, or Coinsurance | 30% Coinsurance<br>after Deductible is met |
| **Professional Services**<br>A separate professional fee for services performed by Physician or Specialist in any setting other than an Office. | No Copayment or Coinsurance<br>after Deductible is met<br>**at an Outpatient Hospital Facility**<br><br>No Copayment or Coinsurance<br>after Deductible is met<br>**at an Inpatient Facility**<br><br>No Copayment or Coinsurance<br>after Deductible is met<br>**at a Mental Health and Substance Abuse Inpatient Facility** | 30% Coinsurance<br>after Deductible is met |

| **Benefit** | In-Network (INET)<br>**Participating Providers**<br>Member Pays | **Out-of-Network (OON)**<br>Member Pays |
|---|---|---|
| **Residential Treatment Center**<br>For Mental Health and Substance Abuse services. | No Copayment or Coinsurance after Deductible is met | 30% Coinsurance after Deductible is met |
| **Skilled Nursing Facility**<br>Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation. | No Copayment or Coinsurance after Deductible is met | 30% Coinsurance after Deductible is met |
| **Emergency and Urgent Care** | | |
| **Ambulance Services** | No Copayment, Deductible, or Coinsurance | No Copayment, Deductible, or Coinsurance |
| **Emergency Room** | 20% Coinsurance after Deductible is met | 20% Coinsurance after In-Network Deductible is met |
| **Urgent Care Services**<br>Urgent Care Services may be received in various settings, please refer to those sections of the Schedule for details on what you will pay. | $25 Copayment per visit **at a Walk-In Center**<br><br>$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**<br>2 times per 12 month period | No Copayment, Deductible, or Coinsurance | No Copayment, Deductible, or Coinsurance |
| **Basic Services** | 40% Coinsurance after Deductible is met | 40% Coinsurance after Deductible is met |
| **Major Services**<br>Including Endodontic, Periodontal, Oral Surgery and Prosthodontic services. | 50% Coinsurance after Deductible is met | 50% Coinsurance after Deductible is met |
| **Orthodontia Services**<br>Medically Necessary only | 50% Coinsurance after Deductible is met | 50% Coinsurance after Deductible is met |

| **Benefit** | In-Network (INET)<br>**Participating Providers**<br>Member Pays | **Out-of-Network (OON)**<br>Member Pays |
|---|---|---|
| **Pediatric Vision Care (For children under age 19)** | | |
| **Prescription Eye Glasses**<br>One pair of frames from the Anthem formulary and lenses or contact lens per plan year.<br><br>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. | No Copayment, Deductible, or Coinsurance **for Single Vision, Bifocal, Trifocal, Lenticular, and standard Progressive Lenses**<br><br>No Copayment, Deductible, or Coinsurance **for Formulary frames** | 50% Coinsurance |
| **Contact Lenses**<br>One set of contact lenses from the Anthem formulary every plan year. Available only if the eyeglass lenses benefit is not used. | No Copayment, Deductible, or Coinsurance **for Elective Contact Lenses**<br><br>No Copayment, Deductible, or Coinsurance **for Non-Elective Contact Lenses** | 50% Coinsurance |
| **Routine Eye Exam by a Specialist**<br>One exam per plan year, limit is combined with Low Vision Exam. | $30 Copayment per visit | 50% Coinsurance |
| **Low Vision Exam by a Specialist**<br>One exam per plan year, limit is combined with Routine Eye Exam. | No Copayment, Deductible, or Coinsurance | 50% Coinsurance |

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