

**Anthem
Small Group Market
Silver 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) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
<p>Plan Deductible</p> <p style="padding-left: 40px;">Individual</p> <p style="padding-left: 40px;">Family</p> <p>In-Network Deductible may not apply to all services.</p>	<p>\$5,500 per Member</p> <p>\$11,000 per Family</p>	<p>\$16,500 per Member</p> <p>\$33,000 per Family</p>
<p>Coinsurance</p> <p>After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.</p>	<p>25% Coinsurance</p>	<p>50% Coinsurance</p>
<p>Out-of-Pocket Limit</p> <p style="padding-left: 40px;">Individual</p> <p style="padding-left: 40px;">Family</p> <p>Includes Deductibles, Copayments and Coinsurance</p>	<p>\$8,500 per Member</p> <p>\$17,000 per Family</p>	<p>\$25,500 per Member</p> <p>\$51,000 per Family</p>

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult / Pediatric Preventive Visit	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible is met
Primary Care Provider Office Visits (PCP) Includes services for illness, injury, follow-up care, telehealth, and consultations	\$40 Copayment per visit	50% Coinsurance after Deductible is met
Online Visits 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 When you visit Live Health Online \$40 Copayment per visit from other online Providers	50% Coinsurance after Deductible is met
Specialist Office Visits (SPC) Includes telehealth, Online visits, and consultations.	\$80 Copayment per visit	50% Coinsurance after Deductible is met
Mental Health and Substance Abuse Office Visit Including Office Visits, telehealth, Outpatient treatment, and in Home treatment.	\$40 Copayment per visit	50% Coinsurance after Deductible is met
Retail Health Clinic	\$40 Copayment per visit	50% 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 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	No Copayment, Deductible, or Coinsurance at Site-of-Service Providers 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% 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 Copayment, Deductible, or Coinsurance at Site-of-Service Providers 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% Coinsurance after Deductible is met
Prescription Drugs – Retail Pharmacy A 30-day supply per Prescription Drug or Prescription Drug refill at 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 per Prescription Drug	50% Coinsurance
Tier 2 – Typically Preferred Brand Prescription Drugs	\$50 Copayment per Prescription Drug	50% Coinsurance
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	30% Coinsurance to a Coinsurance maximum of \$500 per Prescription Drug	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 Drug	50% Coinsurance
Prescription Drugs – Home Delivery (Mail Order) Pharmacy 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 per Prescription Drug	50% Coinsurance
Tier 2 – Typically Preferred Brand Prescription Drugs	\$150 Copayment per Prescription Drug	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 Drug	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 Drug	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	See PCP / SPC Copayment	50% Coinsurance after Deductible is met
Urgent Facility	25% Coinsurance	50% Coinsurance after Deductible is met
Outpatient Hospital	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Home Health Agency	25% Coinsurance after a \$50 Deductible is met	25% Coinsurance after a \$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 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% 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 calendar year. Limits are combined for physical, speech, and occupational therapy.	\$30 Copayment per visit in an Office 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% 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 calendar year.	\$80 Copayment per visit in an Office 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% Coinsurance after Deductible is met
Diabetic Equipment and Supplies	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Durable Medical Equipment (DME)	50% Coinsurance after Deductible is met	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% Coinsurance after \$50 Deductible is met	25% Coinsurance after \$50 Deductible is met
Allergy Testing	\$80 Copayment per visit	50% Coinsurance after Deductible is met
Allergy Treatment Injection, Immunotherapy, or other therapy treatments	\$80 Copayment per visit	50% Coinsurance after Deductible is met
Artificial Limbs Includes associated supplies and equipment	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Cardiac Rehabilitation Therapy	\$80 Copayment per visit in an Office 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% Coinsurance after Deductible is met
Counseling Includes Family Planning and Nutritional Counseling (other than Eating Disorders).	\$40 Copayment per visit	50% Coinsurance after Deductible is met
Dialysis and Hemodialysis	25% Coinsurance in an Office 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Home Dialysis and Infusion Therapy	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Nutritional Counseling for Eating Disorders	\$40 Copayment per visit	50% Coinsurance after Deductible is met
Other Therapy Services Including radiation, chemotherapy, respiratory therapy	25% Coinsurance in an Office 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% Coinsurance after Deductible is met
Prosthetics	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Pulmonary Therapy	\$80 Copayment per visit in an Office 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% Coinsurance after Deductible is met
Facility Services		
Outpatient Services Including surgery, infertility, hospice, and diagnostic colonoscopy.	\$400 Copayment per visit at a Surgical Center 25% Coinsurance after Deductible is met at an Outpatient Hospital Facility	50% 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.	25% Coinsurance after Deductible is met	50% 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.	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Partial Hospitalization and Intensive Outpatient Services in a Facility For Mental Health and Substance Abuse treatment.	No Copayment, Deductible, or Coinsurance	50% 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.	25% Coinsurance after Deductible is met at an Outpatient Hospital Facility 25% Coinsurance after Deductible is met at an Inpatient Facility 25% Coinsurance after Deductible is met at a Mental Health and Substance Abuse Inpatient Facility	50% Coinsurance after Deductible is met
Residential Treatment Center For Mental Health and Substance Abuse services.	25% Coinsurance after Deductible is met	50% 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.	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Emergency and Urgent Care		
Ambulance Services	25% Coinsurance	25% Coinsurance
Emergency Room	25% Coinsurance after Deductible is met	25% Coinsurance after In-Network Deductible is met
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.	\$40 Copayment per visit at a Walk-In Center \$100 Copayment per visit at an Urgent Care Facility (Urgent Care Center)	50% Coinsurance after Deductible is met
Pediatric Dental Care (For children under age 19)		
Diagnostic & Preventive 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 Including Endodontic, Periodontal, Oral Surgery and Prosthodontic services.	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
Orthodontia Services Medically Necessary only	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Pediatric Vision Care (For children under age 19)		
Prescription Eye Glasses One pair of frames from the Anthem formulary and lenses or contact lens per plan year 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 No Cost-Share for Formulary frames	50% Coinsurance
Contact Lenses 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 No Copayment, Deductible, or Coinsurance for Non-Elective Contact Lenses	50% Coinsurance
Routine Eye Exam by a Specialist One exam per plan year, limit is combined with Low Vision Exam.	\$30 Copayment per visit	50% Coinsurance
Low Vision Exam by a Specialist One exam per plan year, limit is combined with Routine Eye Exam.	No Copayment, Deductible, or Coinsurance	50% Coinsurance