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 Surgery Centers (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 www.anthem.com look for the "Site-of-Service (SOS)" indicator under the "Recognitions(/Tier)" link to the right of the Provider's name. You can use the "Recognitions" filter function to only select "Site-of-Service" Providers.

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Plan Deductible **Individual** **Family** In-Network Deductible may not apply to all services.	 $1,500 per Member $3,000 per Family	 $4,500 per Member $9,000 per Family
Coinsurance After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	20% Coinsurance	50% Coinsurance
Out-of-Pocket Limit **Individual** **Family** Includes Deductibles, Copayments and Coinsurance	 $5,500 per Member $11,000 per Family	 $16,500 per Member $33,000 per Family

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Gold Pathway CT PPO

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Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Provider Office and Home Visits (In-Person and/or Virtual Visits) Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care Services" row or section in the Booklet.		
Adult / Pediatric Preventive Visit	No Cost-Share	50% Coinsurance after Deductible is met
Preventive Care for Chronic Conditions (per IRS guidelines) Includes Medical items, equipment and screenings. Please refer to “PreventiveRx Prescription Drugs” in the “Prescription Drugs - Retail Pharmacy” section.	No Cost-Share	50% Coinsurance after Deductible is met
Primary Care Provider Visits (PCP) Includes In-Person and/or Virtual Visits for illness, injury, follow-up care, and consultations.	$25 Copayment per visit **for In-Person Visits** $25 Copayment per visit **for Virtual Visits**	50% Coinsurance after Deductible is met
Specialty Care Provider Visits (SCP) Includes In-Person and/or Virtual Visits.	$60 Copayment per visit **for In-Person Visits** $60 Copayment per visit **for Virtual Visits**	50% Coinsurance after Deductible is met
Mental Health and Substance Use Disorder Provider Visits (MH/SUD) Includes In-Person and/or Virtual Visits, Outpatient treatment, nutritional counseling for eating disorders, and In-Home Behavioral Health Programs.	$25 Copayment per visit **for In-Person Visits** $25 Copayment per visit **for Virtual Visits**	50% Coinsurance after Deductible is met
Retail Health Clinic	$25 Copayment per visit	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Virtual Visits (from Virtual Care Only Providers) You can access Virtual Visits through our mobile app or our website at www.anthem.com.		
Virtual Visits including Primary Care from Virtual Care-Only Providers (Medical Services)	No Cost-Share	50% Coinsurance after Deductible is met
Virtual Visits for Specialty Care Services from Virtual Care-Only Providers	$60 Copayment per visit	50% Coinsurance after Deductible is met
Virtual Visits for Mental Health and Substance Use Disorder Services from Virtual Care-Only Providers	$25 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 visit up to an annual maximum of $375 for MRI, MRA, CAT, CTA, PET and SPECT scans **at Site-of-Service Providers** $75 Copayment per visit up to an annual maximum of $375 for MRI, MRA, CAT, CTA, PET and SPECT scans after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Laboratory Services	No Cost-Share **at Site-of-Service Providers** $60 Copayment per visit 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
Non-Advanced Radiology Including x-ray, Breast Tomosynthesis, and other diagnostic services. Certain services may be covered under the "Preventive Care" benefit if within Federal and/or State regulations.	$25 Copayment per visit **at Site-of-Service Providers** $60 Copayment per visit 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 a 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**.		
PreventiveRx Prescription Drugs Includes Prescription Drugs on the PreventiveRx Plus List when you use an In-Network Pharmacy.	No Cost-Share **for PreventiveRx Prescription drugs on Tier 1** No Cost-Share **for PreventiveRx Prescription drugs on Tier 2**	50% Coinsurance after Deductible is met
Tier 1 – Typically Generic Prescription Drugs	$5 Copayment per Prescription Drug	50% Coinsurance after Deductible is met
Tier 2 – Typically Preferred Brand Prescription Drugs	$60 Copayment per Prescription Drug	50% Coinsurance after Deductible is met
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	25% Coinsurance to a Coinsurance maximum of $500 per Prescription Drug	50% Coinsurance after Deductible is met
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 after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
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. This includes Prescription Drugs on the PreventiveRx Plus List when you use an In-Network Pharmacy and no cost-shares apply. A 30-day supply per Prescription Drug or Prescription Drug refill at an Out-of-Network Pharmacy.		
Tier 1 – Typically Generic Prescription Drugs	$10 Copayment per Prescription Drug	50% Coinsurance after Deductible is met
Tier 2 – Typically Preferred Brand Prescription Drugs	$120 Copayment per Prescription Drug	50% Coinsurance after Deductible is met
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	25% Coinsurance to a Coinsurance maximum of $1,000 per Prescription Drug	50% Coinsurance after Deductible is met
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 after Deductible is met
Prescription Drugs – Administered by a Medical Provider 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	20% Coinsurance	50% Coinsurance after Deductible is met
Urgent Facility	20% Coinsurance after Deductible is met	Same as In-Network for certain services or settings, you may be responsible for amounts that exceed the Maximum Allowed Amount
Outpatient Hospital	$500 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
Home Health Care Including Specialty Prescription Drugs for infusion / injection, other than Chemotherapy.	25% Coinsurance after a $50 Deductible is met	25% Coinsurance after a $50 Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
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 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 plan year. Limits are combined for physical, speech, and occupational therapy.	$30 Copayment per visit **in an Office** $30 Copayment per visit after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Other Services		
Chiropractic Care Up to 20 visits for manipulative treatment per plan year.	$60 Copayment per visit **in an Office** $60 Copayment per visit after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Diabetic Equipment and Supplies Please note Diabetic supplies are covered under the Pharmacy benefit. Please see that section for details.	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Durable Medical Equipment (DME), Medical Devices, and Supplies The cost-shares listed apply when your Provider submits separate bills for the equipment or supplies.	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Home Health Care Services Up to 100 for nursing (intermittent skilled nursing services), therapeutic, and home health aide services visits per plan year provided by a Home Health Care Agency.	25% Coinsurance after a $50 Deductible is met	25% Coinsurance after a $50 Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Acupuncture Includes limited coverage for services provided for pain management.	$60 Copayment per visit **in an Office** $500 Copayment per visit after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Allergy Testing	$60 Copayment per visit	50% Coinsurance after Deductible is met
Allergy Treatment Injection, Immunotherapy, or other therapy treatments.	$60 Copayment per visit **in an Office** $60 Copayment per visit after Deductible is met **at an Outpatient Hospital Facility**	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	$60 Copayment per visit **in an Office** $60 Copayment per visit 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).	$25 Copayment per visit	50% Coinsurance after Deductible is met
Dialysis and Hemodialysis	20% Coinsurance **in an Office** $500 Copayment per visit after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Home Dialysis, Infusion Therapy, and Chemotherapy	25% Coinsurance after Deductible is met	25% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Hospice Outpatient Services Includes Outpatient Hospice services, Home Hospice services, Bereavement, and Outpatient Respite Care.	$500 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
Other Therapy Services Including radiation, chemotherapy, respiratory therapy	20% Coinsurance **in an Office** $500 Copayment per visit after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Prosthetics Including hearing aids and wigs.	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Pulmonary Therapy	$60 Copayment per visit **in an Office** $60 Copayment per visit after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Facility Services		
Outpatient Services Including surgery, infertility, and diagnostic colonoscopy.	$300 Copayment per visit **at a Surgery Center** $500 Copayment per visit after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Inpatient Hospital Acute Care Facility Including mental health, substance use disorder, maternity, infertility, hospice, and Human Organ and Tissue Transplant Services.	$700 Copayment per day up to $2,800 per admission 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.	$700 Copayment per day up to $2,800 per admission after Deductible is met	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Partial Hospitalization Program and Intensive Outpatient Program (PHP/IOP) in a Facility For Mental Health and Substance Use Disorder treatment.	$500 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility** No Cost-Share after Deductible is met **at an Inpatient Facility** No Cost-Share after Deductible is met **at a Mental Health and Substance Use Disorder Inpatient Facility**	50% Coinsurance after Deductible is met
Residential Treatment Center For Mental Health and Substance Use Disorder services.	$700 Copayment per day up to $2,800 per admission 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.	$700 Copayment per day up to $2,800 per admission after Deductible is met	50% Coinsurance after Deductible is met
Emergency and Urgent Care		
Ambulance Services	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met
Emergency Room	20% Coinsurance after Deductible is met	20% 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.	$25 Copayment per visit **at a Walk-In Center** $100 Copayment per visit **at an Urgent Care Facility (Urgent Care Center)**	Same as In-Network for certain services or settings, you may be responsible for amounts that exceed the Maximum Allowed Amount

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Pediatric Dental Care (For children under age 26)		
Diagnostic & Preventive 2 times per 12 month period	No Cost-Share	No Cost-Share
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
Orthodontia Services Medically Necessary only	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Pediatric Vision Care (For Dependent Children under age 26) To receive the In-Network benefit, you must use a Blue View Vision Provider. Visit our website at www.anthem.com or call Member Services at the number on your ID card for help in finding a Blue View Vision Provider.		
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 Cost-Share **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 Cost-Share **for Elective Contact Lenses** No Cost-Share **for Non-Elective Contact Lenses**	50% Coinsurance
Routine Eye Exam by a Specialist One exam per plan year.	$30 Copayment per visit	50% Coinsurance
Low Vision Exam by a Specialist One exam per plan year.	No Cost-Share	50% Coinsurance

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Adult Vision Care (For Subscriber and Spouse Members age 19 and Older) To receive the In-Network benefit, you must use a Blue View Vision Provider. Visit our website at www.anthem.com or call Member Services at the number on your ID card for help in finding a Blue View Vision Provider.		
Prescription Eye Glasses One pair of frames and lenses every other plan year. Covered lenses include factory scratch coating standard at no additional cost when received In-Network.	$20 Copayment **for Single Vision, Bifocal, Trifocal Lenses** Covered up to $130 **for Frames**	Reimbursed up to $25 **for Single Vision Lenses** Reimbursed up to $40 **for Bifocal Lenses** Reimbursed up to $55 **for Trifocal Lenses** Reimbursed up to $45 **for Frames**
Contact Lenses One set of contact lenses every other plan year. Available only if the eyeglass lenses benefit is not used.	Covered up to $80 **for Elective Contact Lenses** No Cost-Share **for Non-Elective Contact Lenses**	Reimbursed up to $60 **for Elective Contact Lenses** Reimbursed up to $210 **for Non-Elective Contact Lenses**
Routine Eye Exam by a Specialist One exam per plan year.	$30 Copayment per visit	Reimbursed up to $30