

**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 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](http://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
<p><b>Plan Deductible</b></p> <p><b>Individual</b></p> <p><b>Family</b></p> <p>In-Network Deductible may not apply to all services.</p>	<p>\$4,500 per Member</p> <p>\$9,000 per Family</p>	<p>\$13,500 per Member</p> <p>\$27,000 per Family</p>
<p><b>Coinsurance</b> After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.</p>	<p>20% Coinsurance</p>	<p>50% Coinsurance</p>
<p><b>Out-of-Pocket Limit</b></p> <p><b>Individual</b></p> <p><b>Family</b></p> <p>Includes Deductibles, Copayments and Coinsurance</p>	<p>\$9,000 per Member</p> <p>\$18,000 per Family</p>	<p>\$27,000 per Member</p> <p>\$54,000 per Family</p>

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
<b>Provider Office and Home Visits (In-Person and/or Virtual Visits)</b> 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.		
<b>Adult / Pediatric Preventive Visit</b>	No Cost-Share	50% Coinsurance after Deductible is met
<b>Preventive Care for Chronic Conditions</b> (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
<b>Primary Care Provider Visits (PCP)</b> Includes In-Person and/or Virtual Visits for illness, injury, follow-up care, and consultations.	\$50 Copayment per visit <b>for In-Person Visits</b>  \$50 Copayment per visit <b>for Virtual Visits</b>	50% Coinsurance after Deductible is met
<b>Specialty Care Provider Visits (SCP)</b> Includes In-Person and/or Virtual Visits.	\$100 Copayment per visit <b>for In-Person Visits</b>  \$100 Copayment per visit <b>for Virtual Visits</b>	50% Coinsurance after Deductible is met
<b>Mental Health and Substance Use Disorder Provider Visits (MH/SUD)</b> Includes In-Person and/or Virtual Visits, Outpatient treatment, nutritional counseling for eating disorders, and In-Home Behavioral Health Programs.	\$50 Copayment per visit <b>for In-Person Visits</b>  \$50 Copayment per visit <b>for Virtual Visits</b>	50% Coinsurance after Deductible is met
<b>Retail Health Clinic</b>	\$50 Copayment per visit	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
<b>Virtual Visits (from Virtual Care Only Providers)</b> You can access Virtual Visits through our mobile app or our website at <a href="http://www.anthem.com">www.anthem.com</a> .		
<b>Virtual Visits including Primary Care</b> from Virtual Care-Only Providers (Medical Services)	No Cost-Share	50% Coinsurance after Deductible is met
<b>Virtual Visits for Specialty Care Services</b> from Virtual Care-Only Providers	\$100 Copayment per visit	50% Coinsurance after Deductible is met
<b>Virtual Visits for Mental Health and Substance Use Disorder Services</b> from Virtual Care-Only Providers	\$50 Copayment per visit	50% Coinsurance after Deductible is met
<b>Outpatient Diagnostic Services</b>		
<b>Advanced Radiology</b> 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 <b>at Site-of-Service Providers</b>  \$75 Copayment per visit up to an annual maximum of \$375 for MRI, MRA, CAT, CTA, PET and SPECT scans after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Laboratory Services</b>	No Cost-Share <b>at Site-of-Service Providers</b>  \$100 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
<p><b>Non-Advanced Radiology</b> Including x-ray, Breast Tomosynthesis, and other diagnostic services.</p> <p>Certain services may be covered under the "Preventive Care" benefit if within Federal and/or State regulations.</p>	<p>\$50 Copayment per visit <b>at Site-of-Service Providers</b></p> <p>\$100 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b></p>	<p>50% Coinsurance after Deductible is met</p>
<p><b>Prescription Drugs – Retail Pharmacy</b> 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. <b>Copayment and Coinsurance maximum amounts shown below are based on a 30-day supply per Prescription Drug or Prescription Drug refill.</b></p>		
<p><b>PreventiveRx Prescription Drugs</b> Includes Prescription Drugs on the PreventiveRx Plus List when you use an In-Network Pharmacy.</p>	<p>No Cost-Share <b>for PreventiveRx Prescription drugs on Tier 1</b></p> <p>No Cost-Share <b>for PreventiveRx Prescription drugs on Tier 2</b></p>	<p>50% Coinsurance after Deductible is met</p>
<p><b>Tier 1 – Typically Generic Prescription Drugs</b></p>	<p>\$5 Copayment per Prescription Drug</p>	<p>50% Coinsurance after Deductible is met</p>
<p><b>Tier 2 – Typically Preferred Brand Prescription Drugs</b></p>	<p>\$60 Copayment per Prescription Drug</p>	<p>50% Coinsurance after Deductible is met</p>
<p><b>Tier 3 – Typically Non-Preferred Brand Prescription Drugs</b></p>	<p>25% Coinsurance to a Coinsurance maximum of \$500 per Prescription Drug</p>	<p>50% Coinsurance after Deductible is met</p>
<p><b>Tier 4 – Typically Specialty Prescription Drugs</b> Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.</p>	<p>30% Coinsurance to a Coinsurance maximum of \$1,000 per Prescription Drug</p>	<p>50% Coinsurance after Deductible is met</p>

Benefit	In-Network (INET) Participating Providers Member Pays	Out-of-Network (OON) Member Pays
<b>Prescription Drugs – Home Delivery (Mail Order) Pharmacy</b> 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.		
<b>Tier 1 – Typically Generic Prescription Drugs</b>	\$10 Copayment per Prescription Drug	50% Coinsurance after Deductible is met
<b>Tier 2 – Typically Preferred Brand Prescription Drugs</b>	\$120 Copayment per Prescription Drug	50% Coinsurance after Deductible is met
<b>Tier 3 – Typically Non-Preferred Brand Prescription Drugs</b>	25% Coinsurance to a Coinsurance maximum of \$1,000 per Prescription Drug	50% Coinsurance after Deductible is met
<b>Tier 4 – Typically Specialty Prescription Drugs</b> 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
<b>Prescription Drugs – Administered by a Medical Provider</b> Including Specialty Drugs and other drugs and serums for infusion or injection. Does not include Drugs provided while you are inpatient at a Facility.		
<b>Medical Office</b>	20% Coinsurance	50% Coinsurance after Deductible is met
<b>Urgent Facility</b>	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
<b>Outpatient Hospital</b>	\$500 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
<b>Home Health Care</b> 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
<b>Therapy Services (Outpatient Rehabilitative and Habilitative)</b>		
<b>Speech Therapy</b> 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 <b>in an Office</b>  \$30 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Physical and Occupational Therapy</b> 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 <b>in an Office</b>  \$30 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Other Services</b>		
<b>Chiropractic Care</b> Up to 20 visits for manipulative treatment per plan year.	\$100 Copayment per visit <b>in an Office</b>  \$100 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Diabetic Equipment and Supplies</b> 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
<b>Durable Medical Equipment (DME), Medical Devices, and Supplies</b> 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
<b>Home Health Care Services</b> 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

<b>Benefit</b>	<b>In-Network (INET) Participating Providers Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Acupuncture</b> Includes limited coverage for services provided for pain management.	\$100 Copayment per visit <b>in an Office</b>  \$500 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Allergy Testing</b>	\$100 Copayment per visit	50% Coinsurance after Deductible is met
<b>Allergy Treatment</b> Injection, Immunotherapy, or other therapy treatments.	\$100 Copayment per visit <b>in an Office</b>  \$100 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Artificial Limbs</b> Includes associated supplies and equipment.	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Cardiac Rehabilitation Therapy</b>	\$100 Copayment per visit <b>in an Office</b>  \$100 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Counseling</b> Includes Family Planning and Nutritional Counseling (other than Eating Disorders).	\$50 Copayment per visit	50% Coinsurance after Deductible is met
<b>Dialysis and Hemodialysis</b>	20% Coinsurance <b>in an Office</b>  \$500 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Home Dialysis, Infusion Therapy, and Chemotherapy</b>	25% Coinsurance after Deductible is met	25% Coinsurance after Deductible is met

<b>Benefit</b>	<b>In-Network (INET) Participating Providers Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Hospice Outpatient Services</b> 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
<b>Other Therapy Services</b> Including radiation, chemotherapy, respiratory therapy	20% Coinsurance <b>in an Office</b>  \$500 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Prosthetics</b> Including hearing aids and wigs.	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Pulmonary Therapy</b>	\$100 Copayment per visit <b>in an Office</b>  \$100 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Facility Services</b>		
<b>Outpatient Services</b> Including surgery, infertility, and diagnostic colonoscopy.	\$500 Copayment per visit <b>at a Surgery Center</b>  \$500 Copayment per visit after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Inpatient Hospital Acute Care Facility</b> 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
<b>Inpatient Rehabilitation Facility</b> 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



<b>Benefit</b>	<b>In-Network (INET) Participating Providers Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Partial Hospitalization Program and Intensive Outpatient Program (PHP/IOP) in a Facility</b> For Mental Health and Substance Use Disorder treatment.	\$500 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
<b>Professional Services</b> 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 <b>at an Outpatient Hospital Facility</b>  No Cost-Share after Deductible is met <b>at an Inpatient Facility</b>  No Cost-Share after Deductible is met <b>at a Mental Health and Substance Use Disorder Inpatient Facility</b>	50% Coinsurance after Deductible is met
<b>Residential Treatment Center</b> 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
<b>Skilled Nursing Facility</b> 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
<b>Emergency and Urgent Care</b>		
<b>Ambulance Services</b>	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met
<b>Emergency Room</b>	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met
<b>Urgent Care Services</b> Urgent Care Services may be received in various settings, please refer to those sections of the Schedule for details on what you will pay.	\$50 Copayment per visit <b>at a Walk-In Center</b>  \$100 Copayment per visit <b>at an Urgent Care Facility (Urgent Care Center)</b>	Same as In-Network for certain services or settings, you may be responsible for amounts that exceed the Maximum Allowed Amount

<b>Benefit</b>	<b>In-Network (INET) Participating Providers Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Pediatric Dental Care (For children under age 26)</b>		
<b>Diagnostic &amp; Preventive</b> 2 times per 12 month period	No Cost-Share	No Cost-Share
<b>Basic Services</b>	40% Coinsurance after Deductible is met	40% Coinsurance after Deductible is met
<b>Major Services</b> Including Endodontic, Periodontal, Oral Surgery and Prosthodontic services.	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Orthodontia Services</b> Medically Necessary only	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Pediatric Vision Care (For Dependent Children under age 26)</b>		
To receive the In-Network benefit, you must use a Blue View Vision Provider. Visit our website at <a href="http://www.anthem.com">www.anthem.com</a> or call Member Services at the number on your ID card for help in finding a Blue View Vision Provider.		
<b>Prescription Eye Glasses</b> 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 <b>for Single Vision, Bifocal, Trifocal, Lenticular, and standard Progressive Lenses</b>  No Cost-Share <b>for Formulary frames</b>	50% Coinsurance
<b>Contact Lenses</b> 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 <b>for Elective Contact Lenses</b>  No Cost-Share <b>for Non-Elective Contact Lenses</b>	50% Coinsurance
<b>Routine Eye Exam by a Specialist</b> One exam per plan year.	\$30 Copayment per visit	50% Coinsurance
<b>Low Vision Exam by a Specialist</b> One exam per plan year.	No Cost-Share	50% Coinsurance

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