

# Anthem Small Group Market Bronze 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.

<b>Benefit</b>	<b>In-Network (INET) Participating Providers Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Plan Deductible</b>  <b>Individual</b>  <b>Family</b>  In-Network Deductible may not apply to all services.	\$10,000 per Member  \$20,000 per Family	\$30,000 per Member  \$60,000 per Family
<b>Coinsurance</b> After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	0% Coinsurance	50% Coinsurance
<b>Out-of-Pocket Limit</b>  <b>Individual</b>  <b>Family</b>  Includes Deductibles, Copayments and Coinsurance	\$10,000 per Member  \$20,000 per Family	\$35,000 per Member  \$70,000 per Family

<b>Benefit</b>	<b>In-Network (INET) Participating Providers Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<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. (Not all services can be delivered through a virtual visit.)		
<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.	No Cost-Share after Deductible is met <b>for In-Person Visits</b>  No Cost-Share after Deductible is met <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.	No Cost-Share after Deductible is met <b>for In-Person Visits</b>  No Cost-Share after Deductible is met <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, psychotherapy, applied behavior analysis (ABA) for autism services, and outpatient treatment.	No Cost-Share after Deductible is met <b>for In-Person Visits</b>  No Cost-Share after Deductible is met <b>for Virtual Visits</b>	50% Coinsurance after Deductible is met
<b>Retail Health Clinic</b>	No Cost-Share after Deductible is met	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 after Deductible is met <b>Virtual Visits Conducted            through our mobile app            and/or website</b>	50% Coinsurance after Deductible is met
<b>Virtual Visits for Specialty Care Services</b> from Virtual Care-Only Providers	No Cost-Share after Deductible is met <b>Virtual Visits Conducted            through our mobile app            and/or website</b>	50% Coinsurance after Deductible is met
<b>Virtual Visits for Mental Health and Substance Use Disorder Services</b> from Virtual Care-Only Providers	No Cost-Share after Deductible is met <b>Virtual Visits Conducted            through our mobile app            and/or website</b>	50% Coinsurance after Deductible is met
<b>Diagnostic Services (Outpatient)</b>		
<b>Advanced Radiology</b> Including MRI, CAT, CT, PET Scans, and other advanced radiology services.	No Cost-Share after Deductible is met <b>at Site-of-Service            Providers</b>  No Cost-Share after Deductible is met <b>at an Outpatient Hospital            Facility</b>	50% Coinsurance after Deductible is met
<b>Laboratory Services</b>	No Cost-Share after Deductible is met <b>at Site-of-Service            Providers</b>  No Cost-Share 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
<b>Non-Advanced Radiology – Diagnostic Imaging Services and Other Electronic Diagnostic Tests</b> Including x-ray, Breast Tomosynthesis, and other electronic diagnostic tests such as, EKG, and EEG.  Certain services may be covered under the “Preventive Care” benefit if within Federal and/or State regulations.	No Cost-Share after Deductible is met <b>at Site-of-Service Providers</b>  No Cost-Share after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<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 (one for each 30-day period) will apply. <b>Copayment amounts shown below are based on a 30-day supply per Prescription Drug or Prescription Drug refill.</b>		
<b>PreventiveRx Prescription Drugs</b> Includes Prescription Drugs on the PreventiveRx Plus List when you use an In-Network Pharmacy.	\$5 Copayment per Prescription Drug Deductible waived <b>for PreventiveRx Prescription drugs on Tier 1</b>  \$60 Copayment per Prescription Drug Deductible waived <b>for PreventiveRx Prescription drugs on Tier 2</b>	50% Coinsurance after Deductible is met
<b>Tier 1 – Typically Generic Prescription Drugs</b>	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Tier 2 – Typically Preferred Brand Prescription Drugs</b>	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Tier 3 – Typically Non-Preferred Brand Prescription Drugs</b>	No Cost-Share 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>Tier 4 – Typically Specialty Prescription Drugs</b> Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<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 two (2) PreventiveRx Retail Pharmacy Copayments for a 90-day supply will apply and the Deductible is waived. 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>	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Tier 2 – Typically Preferred Brand Prescription Drugs</b>	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Tier 3 – Typically Non-Preferred Brand Prescription Drugs</b>	No Cost-Share after Deductible is met	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.	No Cost-Share after Deductible is met	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>	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Urgent Facility</b>	No Cost-Share 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>	No Cost-Share 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

<b>Benefit</b>	<b>In-Network (INET) Participating Providers Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<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.	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share 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.	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Therapy Services for Mental Health and Substance Use Disorders</b> Includes Habilitative and Rehabilitative physical, occupational, or speech therapy, or cognitive rehabilitation therapy, for Mental Health or Substance Use Disorder conditions (based on the primary diagnosis on the claim form).	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share 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.	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share 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.	No Cost-Share 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>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.	No Cost-Share 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>Acupuncture</b> Includes limited coverage for services provided for pain management.	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Allergy Testing</b>	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Allergy Treatment</b> Injection, Immunotherapy, or other therapy treatments.	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share 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.	No Cost-Share 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>Cardiac Rehabilitation Therapy</b>	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Cognitive Rehabilitation Therapy</b>	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Counseling</b> Includes medical office visits for family planning, diabetes education, and nutritional counseling (medical).	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Dialysis and Hemodialysis</b>	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share 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>	No Cost-Share after Deductible is met	25% Coinsurance after Deductible is met
<b>Hospice Outpatient Services</b> Includes Outpatient Hospice services, Home Hospice services, Bereavement, and Outpatient Respite Care.	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Nutritional Counseling for Mental Health and Substances Use Disorders</b> Includes office visits for eating disorders.	No Cost-Share 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>Other Therapy Services</b> Including radiation, chemotherapy, respiratory therapy	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share 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.	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Pulmonary Therapy</b>	No Cost-Share after Deductible is met <b>in an Office</b>  No Cost-Share 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.	No Cost-Share after Deductible is met <b>at a Surgery Center</b>  No Cost-Share 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.	No Cost-Share 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.	No Cost-Share 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.	No Cost-Share 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.	No Cost-Share 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.	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Emergency and Urgent Care</b>		
<b>Ambulance Services</b>	No Cost-Share after Deductible is met	No Cost-Share after In-Network Deductible is met
<b>Emergency Room</b>	No Cost-Share after Deductible is met	No Cost-Share 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.	No Cost-Share after Deductible is met <b>at a Walk-In Center</b>  No Cost-Share after Deductible is met <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>	No Cost-Share after Deductible is met	40% Coinsurance after Deductible is met
<b>Major Services</b> Including Endodontic, Periodontal, Oral Surgery and Prosthodontic services.	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Orthodontia Services</b> Medically Necessary only	No Cost-Share 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	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.	<b>\$20 Copayment for Single Vision, Bifocal, Trifocal Lenses</b>  <b>Covered up to \$130 for Frames</b>	<b>Reimbursed up to \$25 for Single Vision Lenses</b>  <b>Reimbursed up to \$40 for Bifocal Lenses</b>  <b>Reimbursed up to \$55 for Trifocal Lenses</b>  <b>Reimbursed up to \$45 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.	<b>Covered up to \$80 for Elective Contact Lenses</b>  <b>No Cost-Share for Non-Elective Contact Lenses</b>	<b>Reimbursed up to \$60 for Elective Contact Lenses</b>  <b>Reimbursed up to \$210 for Non-Elective Contact Lenses</b>
<b>Routine Eye Exam by a Specialist</b> One exam per plan year.	<b>\$30 Copayment</b>	<b>Reimbursed up to \$30</b>