Schedule of Benefits

ANTHEM

Small Business Health Options Program (SHOP)

Gold Pathway X HMO

This is a brief schedule of benefits. Refer to your Anthem Certificate of Coverage (Booklet) for complete details on benefits, conditions, limitations and exclusions. All benefits described below are per member per Benefit Period.

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.

Covered Service	In-Network Services	Out-Of-Network Services
Cost-Sharing Summary		
Deductible **Individual** **Family** In-Network Deductible may not apply to all services.	 $2,750 per Member $5,500 per Family	Not Applicable
Coinsurance After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	Not Applicable	Not Applicable
Out-of-Pocket Limit **Individual** **Family** Includes all Cost-Shares; Deductible, Coinsurance, and Copayments.	 $4,000 per Member $8,000 per Family	Not Applicable
Preventive Care Services This section does not include all preventive services. Certain diagnostic services provided in relation to the preventive and wellness service will require cost-sharing. For any questions related to coverage or cost-sharing of specific services, contact Customer Service at the phone number located on the back of your ID card or visit www.Anthem.com.		
Adult Preventive Visit	No Cost-Share	Not Covered

Covered Service	In-Network Services	Out-Of-Network Services
Infant / Pediatric Preventive Visit	No Cost-Share	Not Covered
Preventive Care Screenings Including but not limited to: • Routine gynecological care: pap smear, pelvic exam, and screening for cervical cancer, • Prostate screening, • Breast cancer screening, including Mammography screening, • Colorectal cancer screening, • Routine colonoscopy, • Routine vision screening, • Routine hearing screening.	No Cost-Share	Not Covered
Provider Office Visits and Doctor Services (Physician Medical/ Surgical Services)		
Primary Care Provider Office Visits Includes services for illness, injury, follow-up care, surgical procedures done in the office, diagnostic services done in the office, telemedicine, and consultations	$25 Copayment per visit	Not Covered
Specialist Office Visits Includes surgical procedures done in the office, diagnostic services done in the office, telemedicine, and consultations.	$45 Copayment per visit	Not Covered
Mental Health and Substance Abuse Office Visit Including Office Visits, telemedicine, Outpatient treatment, and in Home treatment.	$25 Copayment per visit	Not Covered
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.		Not Covered
Outpatient Hospital Facility	No Cost-Share after Deductible is met	
Inpatient Facility	No Cost-Share after Deductible is met	
Mental Health and Substance Abuse Inpatient Facility	No Cost-Share after Deductible is met	

Covered Service	In-Network Services	Out-Of-Network Services
Retail Health Clinic	$25 Copayment per visit	Not Covered
Online Visits www.LiveHealthOnline.com	$10 Copayment per visit	Not Covered
Hospital / Facility Services		
Inpatient Services Including mental health, substance abuse, maternity, infertility, and hospice, and Human Organ and Tissue Transplant Services.	No Cost-Share after Deductible is met	Not Covered
Skilled Nursing Facility and Inpatient Rehabilitation Up to 90 days per plan year, limit combined for Skilled Nursing Facility and Inpatient Rehabilitation.	No Cost-Share after Deductible is met	Not Covered
Residential Treatment Center	No Cost-Share after Deductible is met	Not Covered
Outpatient Services Including surgery, infertility, and diagnostic colonoscopy **Freestanding Facility** **Outpatient Hospital Facility**	 $200 Copayment per visit No Cost-Share after Deductible is met	Not Covered
Partial Hospitalization and Intensive Outpatient Services For Mental Health and Substance Abuse treatment.	No Cost-Share after Deductible is met	Not Covered
Diagnostic Services		
Advanced Radiology Including MRI, CAT, CT, PET Scans, and other diagnostic services. **Freestanding Facility** **Outpatient Hospital Facility**	 $75 Copayment per service up to an annual maximum of $375 for MRI, MRA, CAT, CTA, PET, and SPECT scans No Cost-Share after Deductible is met	Not Covered

Covered Service	In-Network Services	Out-Of-Network Services
Laboratory Services **Reference Lab / Freestanding Facility** **Outpatient Hospital Facility**	 No Cost-Share No Cost-Share after Deductible is met	Not Covered
Non-Advanced Radiology Including X-ray, Breast Tomosynthesis, and other diagnostic services. **Freestanding Radiology Facility** **Outpatient Hospital Facility**	 No Cost-Share No Cost-Share after Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Therapy Services		
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. **Office** **Outpatient Hospital Facility**	 $30 Copayment per visit No Cost-Share after Deductible is met	Not Covered
Physical 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. **Office** **Outpatient Hospital Facility**	 $30 Copayment per visit No Cost-Share after Deductible is met	Not Covered

Covered Service	In-Network Services	Out-Of-Network Services
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. **Office** **Outpatient Hospital Facility**	 $30 Copayment per visit No Cost-Share after Deductible is met	Not Covered
Chiropractic Care Up to 20 visits per plan year. **Office** **Outpatient Hospital Facility**	 $45 Copayment per visit No Cost-Share after Deductible is met	Not Covered
Allergy Services **Allergy Office Visit/Testing** **Allergy Treatment** Injection, Immunotherapy, or other therapy treatments.	 $45 Copayment per visit $45 Copayment per visit	Not Covered
Other Services		
Diabetic Equipment and Supplies	50% Coinsurance	Not Covered
Durable Medical Equipment (DME) and Prosthetic Devices	50% Coinsurance	Not Covered
Home Health Care Services Up to 100 visits per plan year.	$25 Copayment per visit	Not Covered
Emergency And Urgent Care		
Ambulance Services	No Cost-Share	No Cost-Share
Emergency Room Emergency Room Copayment waived if the Member is admitted directly to the Hospital from the emergency room.	$200 Copayment per visit after Deductible is met	No Cost-Share $200 Copayment per visit after In-Network Deductible is met
Urgent Care Centers	$75 Copayment per visit	Not Covered

Covered Service	In-Network Services	Out-Of-Network Services
Prescription Drugs Copayment and Prescription maximum amounts shown below are based on a 30 day supply per Prescription		
Day Supply Limits Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines. • Retail Pharmacy • Maintenance Pharmacy • Specialty Pharmacy • Home Delivery (Mail Order) Pharmacy	 Up to a 30 day supply Up to a 90 day supply 3 Copayments apply, or $1,500 per Prescription Maximum Up to a 30 day supply Up to a 90 day supply 2.5 Copayments apply on Tier 1 (Copayments are rounded up to the nearest dollar), 3 Copayments apply on Tier 2, or $1,500 per Prescription Maximum	Not Covered
Tier 1 Prescription Drugs	$5 Copayment per Prescription	Not Covered
Tier 2 Prescription Drugs	$50 Copayment per Prescription	Not Covered
Tier 3 Prescription Drugs	50% Coinsurance to a maximum of $500 per Prescription	Not Covered
Tier 4 Prescription Drugs	50% Coinsurance to a maximum of $500 per Prescription	Not Covered
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive 1 time per 6 month period	No Cost-Share	Not Covered
Basic Restorative Services	No Cost-Share after Deductible is met	Not Covered

Covered Service	In-Network Services	Out-Of-Network Services
Endodontic Services	No Cost-Share after Deductible is met	Not Covered
Periodontal Services	No Cost-Share after Deductible is met	Not Covered
Oral Surgery Services	No Cost-Share after Deductible is met	Not Covered
Major Restorative Services	No Cost-Share after Deductible is met	Not Covered
Prosthodontic Services	No Cost-Share after Deductible is met	Not Covered
Orthodontia Services Medically necessary only	No Cost-Share after Deductible is met	Not Covered
Pediatric Vision Care (for children under age 19)		
Prescription Eye Glasses One pair of frames and lenses per plan year	**Lenses:** No Cost-Share **Collection frame:** No Cost-Share **Non–collection frame:** Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Contact Lenses One set of contact lenses (conventional or disposable) every plan year. Available only if the eyeglass lenses benefit is not used.	**Collection Contact Lenses:** No Cost-Share	Not Covered
Routine Eye Exam by a Specialist One exam per plan year	$45 Copayment per visit	Not Covered