Schedule of Benefits

ANTHEM

Small Business Health Options Program (SHOP)

Gold Pathway X PPO

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.	 $2,500 per Member $5,000 per Family	 $7,500 per Member $15,000 per Family
Coinsurance After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	Not Applicable	30% Coinsurance
Out-of-Pocket Limit **Individual** **Family** Includes all Cost-Shares; Deductible, Coinsurance, and Copayments.	 $4,500 per Member $9,000 per Family	 $13,500 per Member $27,000 per Family
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	30% Coinsurance after Deductible is met

Covered Service	In-Network Services	Out-Of-Network Services
Infant / Pediatric Preventive Visit	No Cost-Share	30% Coinsurance after Deductible is met
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	30% Coinsurance after Deductible is met
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	30% Coinsurance after Deductible is met
Specialist Office Visits Includes surgical procedures done in the office, diagnostic services done in the office, telemedicine, and consultations.	$50 Copayment per visit	30% Coinsurance after Deductible is met
Mental Health and Substance Abuse Office Visit Including Office Visits, telemedicine, Outpatient treatment, and in Home treatment.	$25 Copayment per visit	30% Coinsurance after Deductible is met

Covered Service	In-Network Services	Out-Of-Network Services
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.		30% Coinsurance after Deductible is met
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	
Retail Health Clinic	$25 Copayment per visit	30% Coinsurance after Deductible is met
Online Visits www.LiveHealthOnline.com	$10 Copayment per visit	30% Coinsurance after Deductible is met
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	30% Coinsurance after Deductible is met
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	30% Coinsurance after Deductible is met
Residential Treatment Center	No Cost-Share after Deductible is met	30% Coinsurance after Deductible is met
Outpatient Services Including surgery, infertility, and diagnostic colonoscopy		30% Coinsurance after Deductible is met
Freestanding Facility	$200 Copayment per visit	
Outpatient Hospital Facility	No Cost-Share after Deductible is met	

Covered Service	In-Network Services	Out-Of-Network Services
Partial Hospitalization and Intensive Outpatient Services For Mental Health and Substance Abuse treatment.	No Cost-Share after Deductible is met	30% Coinsurance after Deductible is met
Diagnostic Services		
Advanced Radiology Including MRI, CAT, CT, PET Scans, and other diagnostic services.		30% Coinsurance after Deductible is met
Freestanding Facility	$75 Copayment per service up to an annual maximum of $375 for MRI, MRA, CAT, CTA, PET, and SPECT scans	
Outpatient Hospital Facility	No Cost-Share after Deductible is met	
Laboratory Services		30% Coinsurance after Deductible is met
Reference Lab / Freestanding Facility	No Cost-Share	
Outpatient Hospital Facility	No Cost-Share after Deductible is met	
Non-Advanced Radiology Including X-ray, Breast Tomosynthesis, and other diagnostic services.		30% Coinsurance after Deductible is met
Freestanding Radiology Facility	No Cost-Share	
Outpatient Hospital Facility	No Cost-Share after Deductible is met	
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.		30% Coinsurance after Deductible is met
Office	$30 Copayment per visit	
Outpatient Hospital Facility	No Cost-Share after Deductible is met	

Covered Service	In-Network Services	Out-Of-Network Services
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	30% Coinsurance after Deductible is met
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	30% Coinsurance after Deductible is met
Chiropractic Care Up to 20 visits per plan year. **Office** **Outpatient Hospital Facility**	 $50 Copayment per visit No Cost-Share after Deductible is met	30% Coinsurance after Deductible is met
Allergy Services **Allergy Office Visit/Testing** **Allergy Treatment** Injection, Immunotherapy, or other therapy treatments.	 $50 Copayment per visit $50 Copayment per visit	30% Coinsurance after Deductible is met
Other Services		
Diabetic Equipment and Supplies	50% Coinsurance	50% Coinsurance after Deductible is met
Durable Medical Equipment (DME) and Prosthetic Devices	50% Coinsurance	50% Coinsurance after Deductible is met
Home Health Care Services Up to 100 visits per plan year.	$25 Copayment per visit	25% Coinsurance after $50 Deductible is met

Covered Service	In-Network Services	Out-Of-Network Services
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	$200 Copayment per visit after In-Network Deductible is met
Urgent Care Centers	$75 Copayment per visit	30% Coinsurance after Deductible is met
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	Up to a 30 day supply	Up to a 30 day supply
• Maintenance Pharmacy	Up to a 90 day supply 3 Copayments apply, or $1,500 per Prescription Maximum	Up to a 90 day supply
• Specialty Pharmacy	Up to a 30 day supply	Up to a 30 day supply
• Home Delivery (Mail Order) Pharmacy	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	50% Coinsurance
Tier 2 Prescription Drugs	$50 Copayment per Prescription	50% Coinsurance
Tier 3 Prescription Drugs	50% Coinsurance to a maximum of $500 per Prescription	50% Coinsurance

Covered Service	In-Network Services	Out-Of-Network Services
Tier 4 Prescription Drugs	50% Coinsurance to a maximum of $500 per Prescription	50% Coinsurance
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive 1 time per 6 month period	No Cost-Share	No Cost-Share
Basic Restorative Services	40% Coinsurance after Deductible is met	40% Coinsurance after Deductible is met
Endodontic Services	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Periodontal Services	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Oral Surgery Services	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Major Restorative Services	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
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 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.	50% Coinsurance
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	50% Coinsurance

Covered Service	In-Network Services	Out-Of-Network Services
Routine Eye Exam by a Specialist One exam per plan year	$50 Copayment per visit	30% Coinsurance