

## Schedule of Benefits

**ANTHEM**

**Small Business Health Options Program (SHOP)**

**Silver Pathway X HMO w/HSA**

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
<b>Cost-Sharing Summary</b>		
<b>Deductible</b>		Not Applicable
<b>Individual</b>	\$3,000 per Member	
<b>Family</b>	\$6,000 per Family	
<b>Coinsurance</b> After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	20% Coinsurance	Not Applicable
<b>Out-of-Pocket Limit</b>		Not Applicable
<b>Individual</b>	\$5,500 per Member	
<b>Family</b>	\$11,000 per Family	
Includes all Cost-Shares; Deductible, Coinsurance, and Copayments.		
<b>Preventive Care Services</b>		
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 <a href="http://www.Anthem.com">www.Anthem.com</a> .		
<b>Adult Preventive Visit</b>	No Cost-Share	Not Covered
<b>Infant / Pediatric Preventive Visit</b>	No Cost-Share	Not Covered

Covered Service	In-Network Services	Out-Of-Network Services
<p><b>Preventive Care Screenings</b> Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Routine gynecological care: pap smear, pelvic exam, and screening for cervical cancer,</li> <li>• Prostate screening,</li> <li>• Breast cancer screening, including Mammography screening,</li> <li>• Colorectal cancer screening,</li> <li>• Routine colonoscopy,</li> <li>• Routine vision screening,</li> <li>• Routine hearing screening.</li> </ul>	No Cost-Share	Not Covered
<b>Provider Office Visits and Doctor Services (Physician Medical/ Surgical Services)</b>		
<p><b>Primary Care Provider Office Visits</b> Includes services for illness, injury, follow-up care, surgical procedures done in the office, diagnostic services done in the office, telemedicine, and consultations.</p>	\$30 Copayment per visit after Deductible is met	Not Covered
<p><b>Specialist Office Visits</b> Includes surgical procedures done in the office, diagnostic services done in the office, telemedicine, and consultations.</p>	\$50 Copayment per visit after Deductible is met	Not Covered
<p><b>Mental Health and Substance Abuse Office Visit</b> Including Office Visits, telemedicine, Outpatient treatment, and in Home treatment.</p>	No Cost-Share after Deductible is met	Not Covered
<p><b>Professional Services</b> A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.</p> <p><b>Outpatient Hospital Facility</b></p> <p><b>Inpatient Facility</b></p> <p><b>Mental Health and Substance Abuse Inpatient Facility</b></p>	<p>20% Coinsurance after Deductible is met</p> <p>20% Coinsurance after Deductible is met</p> <p>20% Coinsurance after Deductible is met</p>	Not Covered

Covered Service	In-Network Services	Out-Of-Network Services
<b>Retail Health Clinic</b>	\$30 Copayment per visit after Deductible is met	Not Covered
<b>Online Visits</b> www.LiveHealthOnline.com	\$30 Copayment per visit after Deductible is met	Not Covered
<b>Hospital / Facility Services</b>		
<b>Inpatient Services</b> Including mental health, substance abuse, maternity, infertility, and hospice, and Human Organ and Tissue Transplant Services.	20% Coinsurance after Deductible is met	Not Covered
<b>Skilled Nursing Facility and Inpatient Rehabilitation</b> Up to 90 days per plan year, limit combined for Skilled Nursing Facility and Inpatient Rehabilitation.	20% Coinsurance after Deductible is met	Not Covered
<b>Residential Treatment Center</b>	20% Coinsurance after Deductible is met	Not Covered
<b>Outpatient Services</b> Including surgery, infertility, and diagnostic colonoscopy		Not Covered
<b>Freestanding Facility</b>	20% Coinsurance after Deductible is met	
<b>Outpatient Hospital Facility</b>	20% Coinsurance after Deductible is met	
<b>Partial Hospitalization and Intensive Outpatient Services</b> For Mental Health and Substance Abuse treatment.	20% Coinsurance after Deductible is met	Not Covered
<b>Diagnostic Services</b>		
<b>Advanced Radiology</b> Including MRI, CAT, CT, PET Scans, and other diagnostic services.		Not Covered
<b>Freestanding Facility</b>	20% Coinsurance after Deductible is met	
<b>Outpatient Hospital Facility</b>	20% Coinsurance after Deductible is met	

Covered Service	In-Network Services	Out-Of-Network Services
<b>Laboratory Services</b>  <b>Reference Lab / Freestanding Facility</b>  <b>Outpatient Hospital Facility</b>	No Cost-Share after Deductible is met  20% Coinsurance after Deductible is met	Not Covered
<b>Non-Advanced Radiology</b> Including X-ray, Breast Tomosynthesis, and other diagnostic services.  <b>Freestanding Radiology Facility</b>  <b>Outpatient Hospital Facility</b>	20% Coinsurance after Deductible is met  20% Coinsurance after Deductible is met	Not Covered
<b>Outpatient Rehabilitative and Habilitative Therapy Services</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.  <b>Office</b>  <b>Outpatient Hospital Facility</b>	20% Coinsurance after Deductible is met  20% Coinsurance after Deductible is met	Not Covered
<b>Physical 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.  <b>Office</b>  <b>Outpatient Hospital Facility</b>	20% Coinsurance after Deductible is met  20% Coinsurance after Deductible is met	Not Covered

<b>Covered Service</b>	<b>In-Network Services</b>	<b>Out-Of-Network Services</b>
<b>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.		Not Covered
<b>Office</b>	20% Coinsurance after Deductible is met	
<b>Outpatient Hospital Facility</b>	20% Coinsurance after Deductible is met	
<b>Chiropractic Care</b> Up to 20 visits per plan year.		Not Covered
<b>Office</b>	20% Coinsurance after Deductible is met	
<b>Outpatient Hospital Facility</b>	20% Coinsurance after Deductible is met	
<b>Allergy Services</b>		Not Covered
<b>Allergy Office Visit/Testing</b>	20% Coinsurance after Deductible is met	
<b>Allergy Treatment</b> Injection, Immunotherapy, or other therapy treatments.	20% Coinsurance after Deductible is met	
<b>Other Services</b>		
<b>Diabetic Equipment and Supplies</b>	20% Coinsurance after Deductible is met	Not Covered
<b>Durable Medical Equipment (DME) and Prosthetic Devices</b>	20% Coinsurance after Deductible is met	Not Covered
<b>Home Health Care Services</b> Up to 100 visits per plan year.	25% Coinsurance after Deductible is met	Not Covered
<b>Emergency And Urgent Care</b>		
<b>Ambulance Services</b>	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met

Covered Service	In-Network Services	Out-Of-Network Services
<b>Emergency Room</b> 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
<b>Urgent Care Centers</b>	\$75 Copayment per visit after Deductible is met	Not Covered
<b>Prescription Drugs</b> Copayment and Prescription maximum amounts shown below are based on a 30 day supply per Prescription		
<b>Day Supply Limits</b> 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.  <ul style="list-style-type: none"> <li>Retail Pharmacy</li> <li>Maintenance Pharmacy</li> <li>Specialty Pharmacy</li> <li>Home Delivery (Mail Order) Pharmacy</li> </ul>	Up to a 30 day supply  Up to a 90 day supply 3 Copayments apply  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) and 3 Copayments apply on Tier 2	Not Covered
<b>Preventive Rx Prescription Drugs</b>	Applicable Prescription Drug Tiered Copayment, Deductible waived	Not Covered
<b>Tier 1 Prescription Drugs</b>	\$5 Copayment per Prescription after Deductible is met	Not Covered
<b>Tier 2 Prescription Drugs</b>	\$50 Copayment per Prescription after Deductible is met	Not Covered
<b>Tier 3 Prescription Drugs</b>	50% Coinsurance per Prescription after Deductible is met	Not Covered

Covered Service	In-Network Services	Out-Of-Network Services
<b>Tier 4 Prescription Drugs</b>	50% Coinsurance per Prescription after Deductible is met	Not Covered
<b>Pediatric Dental Care (for children under age 19)</b>		
<b>Diagnostic &amp; Preventive</b> 1 time per 6 month period	No Cost-Share	Not Covered
<b>Basic Restorative Services</b>	40% Coinsurance after Deductible is met	Not Covered
<b>Endodontic Services</b>	50% Coinsurance after Deductible is met	Not Covered
<b>Periodontal Services</b>	50% Coinsurance after Deductible is met	Not Covered
<b>Oral Surgery Services</b>	50% Coinsurance after Deductible is met	Not Covered
<b>Major Restorative Services</b>	50% Coinsurance after Deductible is met	Not Covered
<b>Prosthodontic Services</b>	50% Coinsurance after Deductible is met	Not Covered
<b>Orthodontia Services</b> Medically necessary only	50% Coinsurance after Deductible is met	Not Covered
<b>Pediatric Vision Care (for children under age 19)</b>		
<b>Prescription Eye Glasses</b> One pair of frames and lenses per plan year	<b>Lenses:</b> No Cost-Share after Deductible is met <b>Collection frame:</b> No Cost-Share after Deductible is met <b>Non-collection frame:</b> 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

Covered Service	In-Network Services	Out-Of-Network Services
<b>Contact Lenses</b> One set of contact lenses (conventional or disposable) every plan year. Available only if the eyeglass lenses benefit is not used.	<b>Collection Contact Lenses:</b> No Cost-Share after Deductible is met	Not Covered
<b>Routine Eye Exam by a Specialist</b> One exam per plan year	\$50 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met