Anthem
Small Group Market
Gold Pathway X HMO

Schedule of Benefits

Your Plan provides you with the option to lower your out-of-pocket costs for certain services by going to Site-of-Service Providers, Freestanding Providers, or 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" tool on anthem.com look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort by Benefit Tier and show these providers first in your results.

In the following "Schedule of Benefits", Site-of-Service or Freestanding Providers, and Surgical Centers will be shown in the first Cost-Sharing column, otherwise "Not Applicable" will appear and benefits will be available at the In-Network Participating Providers level.

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Plan Deductible			Not Covered
Individual	$2,750 per Member		
Family	$5,500 per Family		
Out-of-Pocket Limit			Not Covered
Individual	$4,000 per Member		
Family	$8,000 per Family		
Includes Deductibles, Copayments and Coinsurance			
Provider Office Visits			
Adult / Pediatric Preventive Visit	Not Applicable	No Cost-share	Not Covered
Primary Care Provider Office Visits Includes services for illness, injury, follow-up care, and consultations	Not Applicable	$25 Copayment per visit	Not Covered
Specialist Office Visits	Not Applicable	$50 Copayment per visit	Not Covered

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Mental Health and Substance Abuse Office Visit	Not Applicable	$25 Copayment per visit	Not Covered
Outpatient Diagnostic Services			
Advanced Radiology CT/PET Scan, MRI	$75 Copayment per service up to an annual maximum of $375 for MRI, MRA, CAT, CTA, PET and SPECT scans **at Site-of-Service or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Laboratory Services	No Cost-Share **at an Independent Lab, Site-of-Service or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Non-Advanced Radiology X-ray, Diagnostic	No Cost-Share **at Site-of-Service or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Mammography Ultrasound	No Cost-Share **at Site-of-Service or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Prescription Drugs – Retail Pharmacy 30-day supply per Prescription Order at a Retail Pharmacy. Up to a 90-day supply is available at Maintenance Pharmacies for Tiers 1, 2, and 3. When you get a 90-day supply at Maintenance Pharmacy, three (3) Retail Pharmacy Copayments or Coinsurance maximums (one for each 30-day period) will apply. **Copayment and Coinsurance maximum amounts shown below are based on a 30-day supply per Prescription Order**.			
Tier 1 - Typically Generic Prescription Drugs	Not Applicable	$5 Copayment per Prescription Order	Not Covered
Tier 2 – Typically Preferred Brand Prescription Drugs	Not Applicable	$50 Copayment per Prescription Order	Not Covered
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	Not Applicable	30% Coinsurance to a Coinsurance maximum of $500 per Prescription Order	Not Covered

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Tier 4 – Typically Specialty Prescription Drugs Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	Not Applicable	30% Coinsurance to a Coinsurance maximum of $1,000 per Prescription Order	Not Covered
Prescription Drugs – Mail Order Pharmacy 90-day supply per Prescription Order for Tiers 1, 2, and 3, and a 30-day supply per Prescription Order for Tier 4.			
Tier 1 - Typically Generic Prescription Drugs	Not Applicable	$13 Copayment per Prescription Order	Not Covered
Tier 2 – Typically Preferred Brand Prescription Drugs	Not Applicable	$150 Copayment per Prescription Order	Not Covered
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	Not Applicable	30% Coinsurance to a Coinsurance maximum of $1,500 per Prescription Order	Not Covered
Tier 4 – Typically Specialty Prescription Drugs Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	Not Applicable	30% Coinsurance to a Coinsurance maximum of $1,000 per Prescription Order	Not Covered
Outpatient Rehabilitative and Habilitative Therapy Services 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.			
Speech Therapy	Not Applicable	$30 Copayment per visit **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Physical and Occupational Therapy	Not Applicable	$30 Copayment per visit **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Other Services			
Chiropractic Care Up to 20 visits per plan year.	Not Applicable	$50 Copayment per visit **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Diabetic Equipment and Supplies	Not Applicable	50% Coinsurance after Deductible is met	Not Covered
Durable Medical Equipment (DME)	Not Applicable	50% Coinsurance after Deductible is met	Not Covered
Home Health Care Services Up to 100 visits per plan year provided by a Home Health Care Agency.	Not Applicable	No Cost-Share after $50 Deductible is met	Not Covered
Outpatient Services In a hospital or ambulatory facility	$250 Copayment per visit **at Surgical Centers or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Inpatient Hospital Services Including mental health, substance abuse, maternity, hospice, and skilled nursing services Please also see “Other Services Continued” section.	Not Applicable	No Cost-Share after Deductible is met **at an acute general Hospital**	Not Covered
Emergency and Urgent Care			
Ambulance Services	No Cost-Share	No Cost-Share	No Cost-Share
Emergency Room	20% Coinsurance after Deductible is met	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met
Urgent Care Services	Not Applicable	$25 Copayment per visit **at a Walk-In Center** $75 Copayment per visit **at an Urgent Care Facility (Urgent Care Center)**	Not Covered

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Pediatric Dental Care (For children under age 19)			
Diagnostic & Preventive	Not Applicable	No Cost-Share	Not Covered
Basic Services	Not Applicable	No Cost-Share after Deductible is met	Not Covered
Major Services	Not Applicable	No Cost-Share after Deductible is met	Not Covered
Orthodontia Services Medically necessary only	Not Applicable	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 or contact lens per plan year	Not Applicable	**Lenses:** No Cost-Share **Collection frame:** No Cost-Share	Not Covered
Routine Eye Exam by a Specialist One exam per plan year	Not Applicable	$50 Copayment per visit	Not Covered
Other Services Continued			
Allergy Office Visits and Allergy Testing	Not Applicable	$50 Copayment per visit	Not Covered
Allergy Treatment Injection, Immunotherapy, or other therapy treatments	Not Applicable	$50 Copayment per visit	Not Covered
Artificial Limbs Includes associated supplies and equipment	Not Applicable	No Cost-Share after Deductible is met	Not Covered
Cardiac Rehab Therapy	Not Applicable	$50 Copayment per visit **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Home Dialysis and Infusion Therapy	Not Applicable	No Cost-Share after Deductible is met	Not Covered

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Inpatient Rehabilitation Facility Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	Not Applicable	No Cost-Share after Deductible is met	Not Covered
Online Visits When you visit www.LiveHealthOnline.com Telehealth is available at your PCP or Specialist Cost-shares listed in the Provider Office Visits section of this Schedule.	No Cost-Share for the first 12 visits, then a $10 Copayment applies **for Online visits other than Mental Health & Substance Abuse** $25 Copayment per visit **for Online Mental Health & Substance Abuse**	Not Applicable	Not Covered
Partial Hospitalization and Intensive Outpatient Services in a Facility For Mental Health and Substance Abuse treatment.	Not Applicable	No Cost-Share after Deductible is met	Not Covered
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.	Not Applicable	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility** No Cost-Share after Deductible is met **at an Inpatient Facility** No Cost-Share after Deductible is met **at an Mental Health and Substance Abuse Inpatient Facility**	Not Covered
Prosthetics	Not Applicable	50% Coinsurance after Deductible is met	Not Covered
Residential Treatment Center For Mental Health and Substance Abuse services.	Not Applicable	No Cost-Share after Deductible is met	Not Covered
Retail Health Clinic	Not Applicable	$25 Copayment per visit	Not Covered

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Skilled Nursing Facility Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	Not Applicable	No Cost-Share after Deductible is met	Not Covered