Anthem
Small Group Market
Platinum Pathway X PPO

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 Applicable		
Individual			$2,000 per Member
Family			$4,000 per Family
Out-of-Pocket Limit			
Individual	$2,500 per Member		$7,500 per Member
Family	$5,000 per Family		$15,000 per Family
Includes Deductibles, Copayments and Coinsurance			
Provider Office Visits			
Adult / Pediatric Preventive Visit	Not Applicable	No Cost-share	30% Coinsurance after Deductible is met
Primary Care Provider Office Visits Includes services for illness, injury, follow-up care, and consultations	Not Applicable	$10 Copayment per visit	30% Coinsurance after Deductible is met
Specialist Office Visits	Not Applicable	$20 Copayment per visit	30% Coinsurance after Deductible is met

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	$10 Copayment per visit	30% Coinsurance after Deductible is met
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**	$75 Copayment per service up to an annual maximum of $375 for MRI, MRA, CAT, CTA, PET and SPECT scans **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Laboratory Services	No Cost-Share **at an Independent Lab, Site-of-Service or Freestanding Providers**	$10 Copayment per service **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Non-Advanced Radiology X-ray, Diagnostic	No Cost-Share **at Site-of-Service or Freestanding Providers**	$40 Copayment per service **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Mammography Ultrasound	No Cost-Share **at Site-of-Service or Freestanding Providers**	$20 Copayment per service **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
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	50% Coinsurance
Tier 2 – Typically Preferred Brand Prescription Drugs	Not Applicable	$50 Copayment per Prescription Order	50% Coinsurance
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	Not Applicable	30% Coinsurance to a Coinsurance maximum of $500 per Prescription Order	50% Coinsurance
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	50% Coinsurance

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
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** $30 Copayment per visit **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Physical and Occupational Therapy	Not Applicable	$30 Copayment per visit **in an Office** $30 Copayment per visit **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Other Services			
Chiropractic Care Up to 20 visits per plan year.	Not Applicable	$20 Copayment per visit **in an Office** $20 Copayment per visit **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Diabetic Equipment and Supplies	Not Applicable	50% Coinsurance	50% Coinsurance after Deductible is met
Durable Medical Equipment (DME)	Not Applicable	50% Coinsurance	50% Coinsurance after Deductible is met

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
Home Health Care Services Up to 100 visits per plan year provided by a Home Health Care Agency.	Not Applicable	$25 Copayment per visit	25% Coinsurance after $50 Deductible is met
Outpatient Services In a hospital or ambulatory facility	$150 Copayment per visit **at Surgical Centers or Freestanding Providers**	$200 Copayment per visit **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Inpatient Hospital Services Including mental health, substance abuse, maternity, hospice, and skilled nursing services Please also see "Other Services Continued" section.	Not Applicable	$300 Copayment per admission **at an acute general Hospital**	30% Coinsurance after Deductible is met
Emergency and Urgent Care			
Ambulance Services	No Cost-Share	No Cost-Share	No Cost-Share
Emergency Room	$200 Copayment per visit	$200 Copayment per visit	$200 Copayment per visit
Urgent Care Services	Not Applicable	$10 Copayment per visit **at a Walk-In Center** $50 Copayment per visit **at an Urgent Care Facility (Urgent Care Center)**	30% Coinsurance after Deductible is met
Pediatric Dental Care (For children under age 19)			
Diagnostic & Preventive	Not Applicable	No Cost-Share	No Cost-Share
Basic Services	Not Applicable	40% Coinsurance	40% Coinsurance after Deductible is met
Major Services	Not Applicable	50% Coinsurance	50% Coinsurance after Deductible is met
Orthodontia Services Medically necessary only	Not Applicable	50% Coinsurance	50% Coinsurance after Deductible is met
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	50% Coinsurance

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
Routine Eye Exam by a Specialist One exam per plan year	Not Applicable	$20 Copayment per visit	30% Coinsurance
Other Services Continued			
Allergy Office Visits and Allergy Testing	Not Applicable	$20 Copayment per visit	30% Coinsurance after Deductible is met
Allergy Treatment Injection, Immunotherapy, or other therapy treatments	Not Applicable	$20 Copayment per visit	30% Coinsurance after Deductible is met
Artificial Limbs Includes associated supplies and equipment	Not Applicable	20% Coinsurance	50% Coinsurance after Deductible is met
Cardiac Rehab Therapy	Not Applicable	$20 Copayment per visit **in an Office** $20 Copayment per visit **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Home Dialysis and Infusion Therapy	Not Applicable	No Cost-Share	30% Coinsurance after Deductible is met
Inpatient Rehabilitation Facility Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	Not Applicable	$300 Copayment per admission	30% Coinsurance after Deductible is met
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 Online visits other than Mental Health & Substance Abuse** $10 Copayment per visit **for Online Mental Health & Substance Abuse**	Not Applicable	Not Applicable
Partial Hospitalization and Intensive Outpatient Services in a Facility For Mental Health and Substance Abuse treatment.	Not Applicable	$200 Copayment per visit	30% Coinsurance after Deductible is met

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
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 **at an Outpatient Hospital Facility** No Cost-Share **at an Inpatient Facility** No Cost-Share **at an Mental Health and Substance Abuse Inpatient Facility**	30% Coinsurance after Deductible is met
Prosthetics	Not Applicable	50% Coinsurance	50% Coinsurance after Deductible is met
Residential Treatment Center For Mental Health and Substance Abuse services.	Not Applicable	$300 Copayment per admission	30% Coinsurance after Deductible is met
Retail Health Clinic	Not Applicable	$10 Copayment per visit	30% Coinsurance after Deductible is met
Skilled Nursing Facility Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	Not Applicable	$300 Copayment per admission	30% Coinsurance after Deductible is met