

**Anthem  
Small Group Market  
Silver Pathway X PPO w/HSA**

**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.

<b>Benefit</b>	<b>In-Network (INET) Site-of-Service or Freestanding Providers Member Pays</b>	<b>In-Network (INET) Participating Providers Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Plan Deductible</b>			
<b>Individual</b>	\$3,000 per Member		\$9,000 per Member
<b>Family</b>	\$6,000 per Family		\$18,000 per Family
<b>Out-of-Pocket Limit</b>			
<b>Individual</b>	\$6,700 per Member		\$20,100 per Member
<b>Family</b>	\$13,400 per Family		\$40,200 per Family
Includes Deductibles, Copayments and Coinsurance			
<b>Provider Office Visits</b>			
<b>Adult / Pediatric Preventive Visit</b>	Not Applicable	No Cost-share	50% Coinsurance after Deductible is met
<b>Primary Care Provider Office Visits</b> Includes services for illness, injury, follow-up care, and consultations	Not Applicable	\$30 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
<b>Specialist Office Visits</b>	Not Applicable	\$50 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met

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<b>Mental Health and Substance Abuse Office Visit</b>	Not Applicable	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Outpatient Diagnostic Services</b>			
<b>Advanced Radiology</b> CT/PET Scan, MRI	20% Coinsurance after Deductible is met <b>at Site-of-Service or Freestanding Providers</b>	20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Laboratory Services</b>	No Cost-Share after Deductible is met <b>at an Independent Lab, Site-of-Service or Freestanding Providers</b>	20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Non-Advanced Radiology</b> X-ray, Diagnostic	20% Coinsurance after Deductible is met <b>at Site-of-Service or Freestanding Providers</b>	20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Mammography Ultrasound</b>	20% Coinsurance after Deductible is met <b>at Site-of-Service or Freestanding Providers</b>	20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Prescription Drugs – Retail Pharmacy</b> 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 (one for each 30-day period) will apply. <b>Copayment amounts shown below are based on a 30-day supply per Prescription Order.</b>			
<b>PreventiveRx Prescription Drugs</b>	Not Applicable	Applicable Prescription Drug Tiered Cost-Share, Deductible waived	50% Coinsurance after Deductible is met
<b>Tier 1 - Typically Generic Prescription Drugs</b>	Not Applicable	\$5 Copayment per Prescription Order after Deductible is met	50% Coinsurance after Deductible is met
<b>Tier 2 – Typically Preferred Brand Prescription Drugs</b>	Not Applicable	\$50 Copayment per Prescription Order after Deductible is met	50% Coinsurance after Deductible is met
<b>Tier 3 – Typically Non-Preferred Brand Prescription Drugs</b>	Not Applicable	30% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met

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<b>Tier 4 – Typically Specialty Prescription Drugs</b> Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	Not Applicable	30% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Prescription Drugs – Mail Order Pharmacy</b> 90-day supply per Prescription Order for Tiers 1, 2, and 3, and a 30-day supply per Prescription Order for Tier 4.			
<b>PreventiveRx Prescription Drugs</b>	Not Applicable	Applicable Prescription Drug Tiered Cost-Share, Deductible waived	Not Covered
<b>Tier 1 - Typically Generic Prescription Drugs</b>	Not Applicable	\$13 Copayment per Prescription Order after Deductible is met	Not Covered
<b>Tier 2 – Typically Preferred Brand Prescription Drugs</b>	Not Applicable	\$150 Copayment per Prescription Order after Deductible is met	Not Covered
<b>Tier 3 – Typically Non-Preferred Brand Prescription Drugs</b>	Not Applicable	30% Coinsurance after Deductible is met	Not Covered
<b>Tier 4 – Typically Specialty Prescription Drugs</b> Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	Not Applicable	30% Coinsurance after Deductible is met	Not Covered
<b>Outpatient Rehabilitative and Habilitative Therapy Services</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>Speech Therapy</b>	Not Applicable	20% Coinsurance after Deductible is met <b>in an Office</b>  20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met

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<b>Physical and Occupational Therapy</b>	Not Applicable	20% Coinsurance after Deductible is met <b>in an Office</b>  20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Other Services</b>			
<b>Chiropractic Care</b> Up to 20 visits per plan year.	Not Applicable	20% Coinsurance after Deductible is met <b>in an Office</b>  20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Diabetic Equipment and Supplies</b>	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Durable Medical Equipment (DME)</b>	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Home Health Care Services</b> Up to 100 visits per plan year provided by a Home Health Care Agency.	Not Applicable	20% Coinsurance after Deductible is met	25% Coinsurance after Deductible is met
<b>Outpatient Services</b> In a hospital or ambulatory facility	20% Coinsurance after Deductible is met <b>at Surgical Centers or Freestanding Providers</b>	20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Inpatient Hospital Services</b> Including mental health, substance abuse, maternity, hospice, and skilled nursing services  Please also see "Other Services Continued" section.	Not Applicable	20% Coinsurance after Deductible is met <b>at an acute general Hospital</b>	50% Coinsurance after Deductible is met
<b>Emergency and Urgent Care</b>			
<b>Ambulance Services</b>	20% Coinsurance after Deductible is met	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met

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<b>Emergency Room</b>	20% Coinsurance after Deductible is met	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met
<b>Urgent Care Services</b>	Not Applicable	\$30 Copayment per visit after Deductible is met <b>at a Walk-In Center</b>  \$75 Copayment per visit after Deductible is met <b>at an Urgent Care Facility (Urgent Care Center)</b>	50% Coinsurance after Deductible is met
<b>Pediatric Dental Care (For children under age 19)</b>			
<b>Diagnostic &amp; Preventive</b>	Not Applicable	No Cost-Share	No Cost-Share
<b>Basic Services</b>	Not Applicable	40% Coinsurance after Deductible is met	40% Coinsurance after Deductible is met
<b>Major Services</b>	Not Applicable	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Orthodontia Services</b> Medically necessary only	Not Applicable	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Pediatric Vision Care (For children under age 19)</b>			
<b>Prescription Eye Glasses</b> One pair of frames and lenses or contact lens per plan year	Not Applicable	<b>Lenses:</b> No Cost-Share after Deductible is met  <b>Collection frame:</b> No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
<b>Routine Eye Exam by a Specialist</b> One exam per plan year	Not Applicable	\$50 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
<b>Other Services Continued</b>			
<b>Allergy Office Visits and Allergy Testing</b>	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Allergy Treatment</b> Injection, Immunotherapy, or other therapy treatments	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Artificial Limbs</b> Includes associated supplies and equipment	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met

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<b>Cardiac Rehab Therapy</b>	Not Applicable	20% Coinsurance after Deductible is met <b>in an Office</b>  20% Coinsurance after Deductible is met <b>at an Outpatient Hospital Facility</b>	50% Coinsurance after Deductible is met
<b>Home Dialysis and Infusion Therapy</b>	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Inpatient Rehabilitation Facility</b> Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Online Visits</b> When you visit <a href="http://www.LiveHealthOnline.com">www.LiveHealthOnline.com</a>  Telehealth is available at your PCP or Specialist Cost-shares listed in the Provider Office Visits section of this Schedule.	No Cost-Share after Deductible is met <b>for Online visits other than Mental Health &amp; Substance Abuse</b>  No Cost-Share after Deductible is met <b>for Online Mental Health &amp; Substance Abuse</b>	Not Applicable	Not Applicable
<b>Partial Hospitalization and Intensive Outpatient Services in a Facility</b> For Mental Health and Substance Abuse treatment.	20% Coinsurance after Deductible is met	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Professional Services</b> A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.	Not Applicable	20% Coinsurance after Deductible is met <b>at Outpatient Hospital Facility</b>  20% Coinsurance after Deductible is met <b>at an Inpatient Facility</b>  20% Coinsurance after Deductible is met <b>at an Mental Health and Substance Abuse Inpatient Facility</b>	50% Coinsurance after Deductible is met

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<b>Prosthetics</b>	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Residential Treatment Center</b> For Mental Health and Substance Abuse services.	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
<b>Retail Health Clinic</b>	Not Applicable	\$30 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
<b>Skilled Nursing Facility</b> Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	Not Applicable	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met