Anthem
Small Group Market
Gold Pathway X HMO

Schedule of Benefits

This is a brief "Schedule of Benefits" which generally describes the Plan's benefits for Covered Services, and the cost-share(s) you must pay, and where services are usually received. Generally your benefits and cost-shares are based on the setting in which Covered Services are received (e.g., in a doctor's office, at an outpatient hospital facility, etc.). 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.

Your Plan provides you with the option to lower your out-of-pocket costs for certain services by going to Site-of-Service 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.

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Plan Deductible **Individual** **Family** In-Network Deductible may not apply to all services.	 $2,750 per Member $5,500 per Family	Not Covered
Coinsurance After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	0% Coinsurance	Not Covered
Out-of-Pocket Limit **Individual** **Family** Includes Deductibles, Copayments and Coinsurance	 $4,000 per Member $8,000 per Family	Not Covered

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Provider Office Visits		
Adult / Pediatric Preventive Visit	No Cost-Share	Not Covered
Primary Care Provider Office Visits Includes services for illness, injury, follow-up care, telehealth, and consultations.	$25 Copayment per visit	Not Covered
Online Visits	No Cost-Share for the first 12 visits, then a $10 Copayment per visit applies **when you visit Live Health Online** $25 Copayment per visit **from other online Providers**	Not Covered
Specialist Office Visits Includes telehealth, and consultations.	$50 Copayment per visit	Not Covered
Mental Health and Substance Abuse Office Visit Including Office Visits, telehealth, Outpatient treatment, and in Home treatment.	$25 Copayment per visit	Not Covered
Retail Health Clinic	$25 Copayment per visit	Not Covered
Outpatient Diagnostic Services		
Advanced Radiology Including MRI, CAT, CT, PET Scans, and other diagnostic services.	$75 Copayment per service up to an annual maximum of $375 for MRI, MRA, CAT, CTA, PET and SPECT scans **at Site-of-Service Providers** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Laboratory Services	No Cost-Share **at Site-of-Service Providers** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Non-Advanced Radiology Including x-ray, Breast Tomosynthesis, and other diagnostic services. Certain screenings may be covered under the "Preventive Care" benefit.	No Cost-Share **at Site-of-Service 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	$5 Copayment per Prescription Order	Not Covered
Tier 2 – Typically Preferred Brand Prescription Drugs	$50 Copayment per Prescription Order	Not Covered
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	30% Coinsurance to a Coinsurance maximum of $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.	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	$13 Copayment per Prescription Order	Not Covered

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Tier 2 – Typically Preferred Brand Prescription Drugs	$150 Copayment per Prescription Order	Not Covered
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	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.	30% Coinsurance to a Coinsurance maximum of $1,000 per Prescription Order	Not Covered
Prescription Drugs – Administered by a Medical Providers Including Specialty Drugs and other drugs and serums for infusion or injection. Does not include Drugs provided while you are inpatient at a Facility.		
Medical Office	No Cost-Share	Not Covered
Urgent Facility	No Cost-Share	Not Covered
Outpatient Hospital	No Cost-Share after Deductible is met	Not Covered
Home Health Agency	25% Coinsurance after a $50 Deductible is met	Not Covered
Therapy Services (Outpatient Rehabilitative and Habilitative)		
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 Copayment per visit **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Physical and 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.	$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) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Other Services		
Chiropractic Care Up to 20 visits for manipulative treatment per plan year.	$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	50% Coinsurance after Deductible is met	Not Covered
Durable Medical Equipment (DME)	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.	25% Coinsurance after a $50 Deductible is met	Not Covered
Allergy Testing	$50 Copayment per visit	Not Covered
Allergy Treatment Injection, Immunotherapy, or other therapy treatments	$50 Copayment per visit	Not Covered
Artificial Limbs Includes associated supplies and equipment	No Cost-Share after Deductible is met	Not Covered
Cardiac Rehab Therapy	$50 Copayment per visit **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Counseling Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders).	$25 Copayment per visit	Not Covered
Dialysis and Hemodialysis	No Cost-Share **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Home Dialysis and Infusion Therapy	25% Coinsurance after Deductible is met	Not Covered
Nutritional Counseling for Eating Disorders	$25 Copayment per visit	Not Covered
Other Therapy Services Including radiation, chemo, respiratory	No Cost-Share **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Prosthetics	50% Coinsurance after Deductible is met	Not Covered
Pulmonary	$50 Copayment per visit **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Facility Services		
Outpatient Services Including surgery, infertility, hospice, and diagnostic colonoscopy.	$300 Copayment per visit **at a Surgical Center** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	Not Covered
Inpatient Hospital Acute Care Facility Including mental health, substance abuse, maternity, infertility, hospice, and Human Organ and Tissue Transplant Services.	No Cost-Share after Deductible is met	Not Covered
Inpatient Rehabilitation Facility Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	No Cost-Share after Deductible is met	Not Covered

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Partial Hospitalization and Intensive Outpatient Services in a Facility For Mental Health and Substance Abuse treatment.	No Cost-Share	Not Covered
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.	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 a Mental Health and Substance Abuse Inpatient Facility**	Not Covered
Residential Treatment Center For Mental Health and Substance Abuse services.	No Cost-Share after Deductible is met	Not Covered
Skilled Nursing Facility Up to 90 days per plan year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	No Cost-Share after Deductible is met	Not Covered
Emergency and Urgent Care		
Ambulance Services	No Cost-Share	No Cost-Share
Emergency Room	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met
Urgent Care Services Urgent Care Services may be received in various settings, please refer to those sections of the Schedule for details on what you will pay.	$25 Copayment per visit **at a Walk-In Center** $100 Copayment per visit **at an Urgent Care Facility (Urgent Care Center)**	Not Covered
Pediatric Dental Care (For children under age 19)		
Diagnostic & Preventive 2 times per 12 month period	No Cost-Share	Not Covered

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Basic Services	No Cost-Share after Deductible is met	Not Covered
Major Services Including Endodontic, Periodontal, Oral Surgery and Prosthodontic services.	No Cost-Share after Deductible is met	Not Covered
Orthodontia Services Medically necessary only	No Cost-Share after Deductible is met	Not Covered
Pediatric Vision Care (For children under age 19)		
Prescription Eye Glasses One pair of frames from the Anthem formulary and lenses or contact lens per plan year. Covered lenses include factory scratch coating, UV coating, Anti-Reflective coating, tints, Glass Grey #3, standard polycarbonate and standard photochromic lenses at no additional cost when received In-Network.	No Cost-Share **for Single Vision, Bifocal, Trifocal, Lenticular, and standard Progressive Lenses** No Cost-Share **for Formulary frames**	Not Covered
Contact Lenses One set of contact lenses from the Anthem formulary every plan year. Available only if the eyeglass lenses benefit is not used.	No Cost-Share **for Elective Contact Lenses** No Cost-Share **for Non-Elective Contact Lenses**	Not Covered
Routine Eye Exam by a Specialist One exam per plan year, limit is combined with Low Vision Exam.	$30 Copayment per visit	Not Covered
Low Vision Exam by a Specialist One exam per plan year, limit is combined with Routine Eye Exam.	No Cost-Share	Not Covered