Anthem
Small Group Market
Silver Pathway X PPO

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.	 $5,500 per Member $11,000 per Family	 $16,500 per Member $33,000 per Family
Coinsurance After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	25% Coinsurance	50% Coinsurance
Out-of-Pocket Limit **Individual** **Family** Includes Deductibles, Copayments and Coinsurance	 $8,150 per Member $16,300 per Family	 $24,450 per Member $48,900 per Family

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Provider Office Visits		
Adult / Pediatric Preventive Visit	No Cost-Share	50% Coinsurance after Deductible is met
Primary Care Provider Office Visits Includes services for illness, injury, follow-up care, telehealth, and consultations.	$40 Copayment per visit	50% Coinsurance after Deductible is met
Online Visits	No Cost-Share for the first 12 visits, then a $15 Copayment per visit applies **when you visit Live Health Online** $40 Copayment per visit **from other online Providers**	50% Coinsurance after Deductible is met
Specialist Office Visits Includes telehealth, and consultations.	$80 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
Mental Health and Substance Abuse Office Visit Including Office Visits, telehealth, Outpatient treatment, and in Home treatment.	$40 Copayment per visit	50% Coinsurance after Deductible is met
Retail Health Clinic	$40 Copayment per visit	50% Coinsurance after Deductible is met
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** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Laboratory Services	No Cost-Share **at Site-of-Service Providers** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
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** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% 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	$5 Copayment per Prescription Order	50% Coinsurance
Tier 2 – Typically Preferred Brand Prescription Drugs	$50 Copayment per Prescription Order	50% Coinsurance
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	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.	30% Coinsurance to a Coinsurance maximum of $1,000 per Prescription Order	50% Coinsurance
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	50% Coinsurance
Tier 2 – Typically Preferred Brand Prescription Drugs	$150 Copayment per Prescription Order	50% Coinsurance

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	30% Coinsurance to a Coinsurance maximum of $1,500 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.	30% Coinsurance to a Coinsurance maximum of $1,000 per Prescription Order	50% Coinsurance
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	25% Coinsurance	50% Coinsurance after Deductible is met
Urgent Facility	25% Coinsurance	50% Coinsurance after Deductible is met
Outpatient Hospital	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Home Health Agency	25% Coinsurance after a $50 Deductible is met	25% Coinsurance after a $50 Deductible is met
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** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
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** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met

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.	$80 Copayment per visit after Deductible is met **in an Office** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Diabetic Equipment and Supplies	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Durable Medical Equipment (DME)	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
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	25% Coinsurance after a $50 Deductible is met
Allergy Testing	$80 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
Allergy Treatment Injection, Immunotherapy, or other therapy treatments	$80 Copayment per visit after Deductible is met	50% Coinsurance after Deductible is met
Artificial Limbs Includes associated supplies and equipment	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Cardiac Rehab Therapy	$80 Copayment per visit after Deductible is met **in an Office** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Counseling Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders).	$40 Copayment per visit	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Dialysis and Hemodialysis	25% Coinsurance **in an Office** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Home Dialysis and Infusion Therapy	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Nutritional Counseling for Eating Disorders	$40 Copayment per visit	50% Coinsurance after Deductible is met
Other Therapy Services Including radiation, chemo, respiratory	25% Coinsurance **in an Office** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Prosthetics	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Pulmonary	$80 Copayment per visit after Deductible is met **in an Office** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Facility Services		
Outpatient Services Including surgery, infertility, hospice, and diagnostic colonoscopy.	$400 Copayment per visit **at a Surgical Center** 25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility**	50% Coinsurance after Deductible is met
Inpatient Hospital Acute Care Facility Including mental health, substance abuse, maternity, infertility, hospice, and Human Organ and Tissue Transplant Services.	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met

Benefit	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.	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Partial Hospitalization and Intensive Outpatient Services in a Facility For Mental Health and Substance Abuse treatment.	No Cost-Share	50% Coinsurance after Deductible is met
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.	25% Coinsurance after Deductible is met **at an Outpatient Hospital Facility** 25% Coinsurance after Deductible is met **at an Inpatient Facility** 25% Coinsurance after Deductible is met **at a Mental Health and Substance Abuse Inpatient Facility**	50% Coinsurance after Deductible is met
Residential Treatment Center For Mental Health and Substance Abuse services.	25% Coinsurance after Deductible is met	50% 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.	25% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Emergency and Urgent Care		
Ambulance Services	25% Coinsurance	25% Coinsurance
Emergency Room	25% Coinsurance after Deductible is met	25% Coinsurance after In-Network Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
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.	$40 Copayment per visit **at a Walk-In Center** $100 Copayment per visit **at an Urgent Care Facility (Urgent Care Center)**	50% Coinsurance after Deductible is met
Pediatric Dental Care (For children under age 19)		
Diagnostic & Preventive 2 times per 12 month period	No Cost-Share	No Cost-Share
Basic Services	40% Coinsurance after Deductible is met	40% Coinsurance after Deductible is met
Major Services Including Endodontic, Periodontal, Oral Surgery and Prosthodontic services.	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Orthodontia Services Medically necessary only	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
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**	50% Coinsurance
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**	50% Coinsurance
Routine Eye Exam by a Specialist One exam per plan year, limit is combined with Low Vision Exam.	$40 Copayment per visit	50% Coinsurance

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Low Vision Exam by a Specialist One exam per plan year, limit is combined with Routine Eye Exam.	No Cost-Share	50% Coinsurance