HealthTrust

Anthem BlueCross BlueShield

BlueChoice®
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$20 per visit	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Physician at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$20 per visit	
Emergency Room Copayment	$100 per visit	
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of an illness or injury.	$50 per visit	N/A
Standard Deductible	N/A	$250 per Member, per year $500 per family, per year
Standard Coinsurance	N/A	20%
Coinsurance Maximum	N/A	$900 per Member, per year $1,800 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	$100 per Member, per year 20%	$100 per Member, per year 20%
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, penalties, out-of-network expenses, amounts over the Maximum Allowed Amount or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year	N/A
Inpatient Precertification Penalty	N/A	$500

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)† For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.† -Routine hearing exams - One exam each year.†	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider		
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections)	You pay $0	
Office surgery (including anesthesia)		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA, MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."	

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† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center		
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia	You pay $0	
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation		
Laboratory and x-ray tests (including ultrasounds)		
Emergency Room Visits and Urgent Care Facility Visits		
Use of the emergency room (The Copayment is waived if You are admitted)	Emergency Room Copayment	
Use of a licensed hospital's urgent care facility	Urgent Care Facility Copayment	Standard Deductible and Coinsurance, plus any balances
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0	
Laboratory and x-ray tests		
Ambulance Services Medically Necessary Emergency Transport	You pay $0	
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy	You pay $0	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment	
Chiropractic Care • **Office visit** - up to 35 visits per Member, per year	You pay $0	
• **X-ray tests** furnished by a chiropractor		
Early Intervention Services	Visit Copayment or Specialty Visit Copayment	
IV. Home Care		
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services	You pay $0	
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance	Subject to the DME Deductible and Coinsurance, plus any balances

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	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office Visits		
Mental Health Visits - Unlimited Medically Necessary visits **Substance Abuse Visits** - Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	You pay $0	
VI. Prescription Eyewear		
N/A		

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