HealthTrust

Anthem BlueCross BlueShield

# Lumenos Preferred Blue®
# 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 | Network Benefits | Out-of-Network Benefits* |
|---|---|---|
| | YOUR COST | |
| **Visit Copayment**<br>Applies each time You visit a Preferred Provider or Preferred obstetrical/gynecological specialist. | N/A | N/A |
| **Specialty Visit Copayment**<br>Applies each time You visit a specialist. This Copayment also applies each time You visit a Preferred Physician at a Preferred Walk-In Center for diagnosis, care and treatment of an illness or injury. | N/A | |
| **Emergency Room Copayment** | N/A | |
| **Urgent Care Facility Copayment**<br>Applies each time You visit a Preferred licensed hospital's urgent care facility for diagnosis, care and treatment of an illness or injury. | N/A | N/A |
| **Standard Deductible+** | $2,500 per Member, per year<br>$5,000 per 2-person or family, per year | |
| **Standard Coinsurance+** | N/A | 30% |
| **Coinsurance Maximum** | N/A | $2,500 per Member, per year<br>$5,000 per 2-person or family, per year |
| **Durable Medical Equipment, Medical Supplies and Prosthetics**<br><br>**Deductible**<br>**Coinsurance** | <br><br>Standard Deductible<br>N/A | <br><br>Standard Deductible<br>Standard Coinsurance |
| **Out-of-Pocket Limit****<br>Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, amounts over the Maximum Allowed Amount or charges for noncovered services. | $2,500 per Member, per year<br>$5,000 per family, per year | $5,000 per Member, per year<br>$10,000 per family, per year |
| **Inpatient Precertification Penalty** | N/A | N/A |

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Out-of-Network 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.

+If You are enrolled at the 2-person or family level, eligible expenses incurred by You or any of Your enrolled family members count toward satisfying the entire 2-person/family deductible and/or coinsurance.

**Please note that throughout this schedule any reference to year means plan year unless otherwise noted. Plan year is July 1 through June 30.**

# Coverage Outline

| | Network Benefits | Out-of-Network Benefits* |
|---|---|---|
| | YOUR COST | |
| **Medical/Surgical Care** | | |
| **I. Inpatient Services** | | |
| **In a Short Term General Hospital** (Facility charges for medical, surgical and maternity admissions) | Standard Deductible | 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) | | |
| **Inpatient physician and professional services** (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)<br><br>Skilled Nursing Facility admissions are 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:**<br><br>-Immunizations for babies, children and adults (including travel and rabies immunizations)<br>-Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy<br>-Routine physical exams for babies, children and adults (including one annual gynecological exam)<br>-Lead screening<br>-Outpatient/office contraceptive services<br>-Nutrition counseling<br>-Routine vision exams<br>-Routine hearing exams | 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, telemedicine and online visits, consultations, medical treatments and Preferred Provider services at a Network Walk-In Center | Standard Deductible | Standard Deductible and Coinsurance, plus any balances |
| Injections (including allergy injections) | | |
| 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)<br>Please see Your Subscriber Certificate for information about maternity care. | 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 Benefits and Out-of-Network Benefits counts toward this limit.

| | Network Benefits | Out-of-Network 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, telemedicine and online visits | Standard Deductible | Standard Deductible and Coinsurance, plus any balances |
| Services of a surgeon, operating room for surgery and anesthesia | | |
| Physician and professional services for the delivery of a baby or management of therapy<br><br>Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA<br><br>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 | Standard Deductible | Standard Deductible and Coinsurance, plus any balances |
| Use of a licensed hospital's urgent care facility | | |
| Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs | | |
| Laboratory and x-ray tests | | |
| **Ambulance Services**<br>Medically Necessary Emergency Transport | Standard Deductible | |
| **III. Outpatient Physical Rehabilitation Services** | | |
| **Physical Therapy and Occupational Therapy and Speech Therapy**<br>Up to a combined maximum of 60 visits per Member, per year† | Standard Deductible | Standard Deductible and Coinsurance, plus any balances |
| **Cardiac Rehabilitation Visits** | | |
| **Chiropractic Care**<br>• **Office visit** | | |
| • **X-ray tests** furnished by a chiropractor | | |
| **Early Intervention Services** | | |
| **IV. Home Care** | | |
| **Physician services**<br>Medical exams, injections, medical treatments, surgery and anesthesia, telemedicine and online visits | Standard Deductible | Standard Deductible and Coinsurance, plus any balances |
| **Home Health Agency services** | | |
| **Hospice** | | |
| **Infusion Therapy** | | |
| **Durable Medical Equipment, Medical Supplies and Prosthetics** | | |

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| | Network Benefits | Out-of-Network Benefits* |
|---|---|---|
| | **YOUR COST** | |
| **V. Behavioral Health Care (Mental Health and Substance Abuse Care)** | | |
| **Network Benefits** are available when You obtain Covered Services from a Preferred Provider, as approved in advance.<br>**Out-of-Network Benefits** are available when You obtain Covered Services from any Eligible Mental Health or Substance Abuse Provider, as approved in advance. | | |
| **Outpatient/Office/Telemedicine/Online Visits** | | |
| **Mental Health Visits:** Unlimited Medically Necessary visits<br><br>**Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services) | Standard Deductible | Standard Deductible and Coinsurance, plus any balances |
| **Partial Hospitalization and Intensive Outpatient Treatment Programs** | | |
| **Mental Disorders**: Unlimited Medically Necessary care<br><br>**Substance Abuse Conditions**: Medically Necessary care for rehabilitation and detoxification | Standard Deductible | Standard Deductible and Coinsurance, plus any balances |
| **Inpatient Care** | | |
| **Mental Disorders**:<br>Unlimited Medically Necessary Inpatient days<br><br>**Substance Abuse Conditions:**<br>• Medical detoxification days - Unlimited Medically Necessary Inpatient days<br>• Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days | Standard Deductible | Standard Deductible and Coinsurance, plus any balances |
| **Scheduled Ambulance Transport**<br>Limited to Medically Necessary transport from one facility to another | Standard Deductible | |
| **VI. Prescription Eyewear** | | |
| N/A | | |
| **VII. Prescription Drugs** | | |
| Subject to any Standard Deductible and/or Standard Coinsurance shown on Page 1 of this Cost Sharing Schedule. Benefits and limitations are stated in Your Pharmacy Rider. | | |

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