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	**Option 1** *When Your PCP provides or refers Your care*	**Option 2** *When You seek care directly from a BlueChoice provider*	**Option 3*** *When You seek care from any out-of-network provider*
	YOUR COST		
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$10 per visit	$30 per visit	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Walk-In Center for diagnosis, care and treatment of an illness or injury.	$10 per visit	$30 per visit	N/A
Emergency Room Copayment	$50 per visit		
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's urgent care facility for diagnosis, care and treatment of an illness or injury.	$50 per visit	$50 per visit	N/A
Standard Deductible	N/A	N/A	$150 per Member, per year $450 per family, per year
Standard Coinsurance	N/A	20%	20%
Coinsurance Maximum	N/A	$600 per Member, per year $1,800 per family, per year	$900 per Member, per year $2,700 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics			
Deductible	N/A	N/A	N/A
Coinsurance	N/A	20%	20%
Out-of-Pocket Limit	$3,000 per Member, per year $6,000 per family, per year		N/A
The **Out-of-Pocket Limit** includes all Deductibles, Coinsurance, and Copayments You pay during a year for medical and prescription expenses under this medical plan and Your HealthTrust prescription benefit program. It does not include Your premium, amounts over the Maximum Allowed Amount, penalties, or charges for noncovered services. Once the combined Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.			
Inpatient Precertification Penalty	N/A	N/A	$500

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

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 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.

Coverage Outline

	Option 1 *When Your PCP provides or refers Your care*	Option 2 *When You seek care directly from a BlueChoice provider*	Option 3* *When You seek care from any out-of-network provider*
	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 Coinsurance	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges)			
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)			
II. Outpatient Services			
Preventive Care			
Preventive Care and screenings as required by law or permitted by the Plan 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 -Diabetes management program -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	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 Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (except allergy injections)	You pay $0	You pay $0	
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		Standard Coinsurance	
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 Option 1, 2 or 3 Benefits counts toward this limit.

	Option 1 *When Your PCP provides or refers Your care*	Option 2 *When You seek care directly from a BlueChoice provider*	Option 3* *When You seek care from any out-of-network provider*
	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	Visit Copayment or Specialty Visit Copayment	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	Standard Coinsurance	
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)		You pay $0	
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	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	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 Coinsurance	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	
Chiropractic Care • **Office visit** - unlimited		N/A	
• **X-ray tests** furnished by a chiropractor	You pay $0		
Early Intervention Services	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	
IV. Home Care			
Physician services Medical exams, injections, medical treatments, surgery and anesthesia, telemedicine and online visits	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services	You pay $0	Standard Coinsurance	
Hospice			
Infusion Therapy			
Durable Medical Equipment, Medical Supplies and Prosthetics			Standard Coinsurance, plus any balances

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† Any combination of Option 1, 2 or 3 Benefits counts toward this limit.

Option 2 Benefits are not available for Behavioral Health care.	**Option 1** *When You obtain care from a Network Provider*	**Option 3*** *When You obtain care from any Eligible Mental Health or Substance Abuse Provider*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office/Telemedicine/Online 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		
Benefits are limited to a maximum of **$40** per Member, every two years. Please refer to Your Prescription Eyewear Rider for more information.		

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