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 Network Provider*	**Option 3*** *When You seek care directly from an Out-of-Network Provider*
	YOUR COST		
Visit Copayment Applies each time You visit Your Network Primary Care Provider (PCP) or Network obstetrician/gynecologist (OB/GYN).	$20 per visit	$50 per visit	N/A
Specialty Visit Copayment Applies each time You visit a Network specialist.	$20 per visit	$50 per visit	N/A
Walk-In Center Copayment	$20 per visit		
Urgent Care Facility Copayment	$50 per visit		
Emergency Room Copayment	$100 per visit		
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	$100 per Member, per year
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 plan. 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

* 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 refer to 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.

Please note that throughout this Cost Sharing Schedule any reference to year means Plan Year unless otherwise noted. Plan Year is July 1 through June 30.

Coverage Outline	Option 1 *When Your PCP provides or refers Your care*	Option 2 *When You seek care directly from a Network Provider*	Option 3* *When You seek care directly from an Out-of-Network Provider*
	YOUR COST		
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: -Routine physical exams for babies, children and adults (including one annual gynecological exam†) -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as mammograms, pap smears, prostate-specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -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, Walk-In Center or Retail Health Clinic, 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, and medical treatments	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)			
Surgery and anesthesia			
Laboratory tests (including allergy testing)			
X-ray tests (including ultrasound)			
MRA, MRI, PET, SPECT, CT Scan and CTA		Standard Coinsurance	
Medical supplies (including hearing aids), chemotherapy, infusion therapy, and drugs			
Provider services at a Walk-In Center or Retail Health Clinic	Walk-In Center Copayment		
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.

^ A PCP Referral is not required for these services. However, Covered Services must be provided by a Network Provider. Otherwise, only Option 3 Benefits are available.

****** For non-emergency services furnished by an out-of-network provider within an in-network facility, Your cost will be the in-network cost, unless you are provided notice and give your consent. Please refer to Your Subscriber Certificate for details.

	Option 1 *When Your PCP provides or refers Your care*	**Option 2** *When You seek care directly from a Network Provider*	**Option 3*** *When You seek care directly from an 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			
Physician and professional services for management of therapy			
Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA			
Fees for use of a facility, medical supplies (including hearing aids), 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 an Urgent Care Facility	Urgent Care Facility Copayment		
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0	You pay $0	Standard Deductible and Coinsurance, plus any balances††
Laboratory and x-ray tests			
Ambulance Services			
Medically Necessary ambulance 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	Specialty Visit Copayment	Specialty Visit Copayment	
Chiropractic Care^ • **Office visit** - unlimited			
• **X-ray tests** furnished by a chiropractor	You pay $0	You pay $0	
Early Intervention Services	You pay $0	You pay $0	You pay $0*
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	Subject to the DME Deductible, Coinsurance, plus any balances

***** 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 refer to Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification by Anthem. Please refer to Your Subscriber Certificate for details.

^ A PCP Referral is not required for these services. However, Covered Services must be provided by a Network Provider. Otherwise, only Option 3 Benefits are available.

†† For out-of-network emergency services, Your cost will be the in-network cost, except for some post stabilization services for which you are provided notice and give consent. Please refer to Your Subscriber Certificate for details.

****** For non-emergency services furnished by an out-of-network provider within an in-network facility, Your cost will be the in-network cost, unless you are provided notice and give your consent. Please refer to Your Subscriber Certificate for details.

Option 2 Benefits are not available for Behavioral Health care. Care received directly from a Network Provider is covered under Option 1.

	Option 1 *When You seek care directly from a Network Provider*	**Option 3*** *When You seek care directly from an Out-of-Network Provider*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Use Care)^		
Outpatient/Office/Telemedicine/Online Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Use Care Visits:** Unlimited Medically Necessary visits (including detoxification and substance use rehabilitation services) **Applied Behavioral Analysis:** Unlimited Medically Necessary visits for treatment of pervasive developmental disorder or autism.	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 Use Disorders:** 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 Use Disorders:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance Use Disorder rehabilitation - Unlimited Medically Necessary Inpatient days	You pay $0	Standard Deductible and Coinsurance, plus any balances**
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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^ A PCP Referral is not required for these services. However, Covered Services must be provided by a Network Provider. Otherwise, only Option 3 Benefits are available.

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