HealthTrust

Anthem

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 Applies each time You visit Your Network Primary Care Provider (PCP) or Network obstetrician/gynecologist (OB/GYN).	N/A	N/A
Specialty Visit Copayment Applies each time You visit a Network specialist.	N/A	
Walk-In Center Copayment	N/A	
Urgent Care Facility Copayment	N/A	N/A
Emergency Room Copayment	N/A	
Standard Deductible+	$2,500 per Member, per year $5,000 per 2-person or family, per year	
Standard Coinsurance	N/A	30%
Coinsurance Maximum+	N/A	$2,500 per Member, per year $5,000 per 2-person or family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 Standard Deductible N/A	 Standard Deductible Standard Coinsurance
Out-of-Pocket Limit+	$2,500 per Member, per year $5,000 per family, per year	$5,000 per Member, per year $10,000 per family, per year
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. 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

***** 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 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.

+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 Cost Sharing 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	
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 provider and professional services (Such as provider visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)		
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 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 -Routine hearing exams	You pay $0	Standard Deductible and Coinsurance, plus any balances**
Medical/Surgical Care in a Provider'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, medical treatments, and Provider services at a Walk-In Center or Retail Health Clinic	Standard Deductible	Standard Deductible and Coinsurance, plus any balances**
Injections (except allergy injections)		
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		
Medical supplies (including hearing aids), chemotherapy, infusion therapy, and drugs		
Maternity care (prenatal and postpartum visits) 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.

** 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.

	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 provider, telemedicine and online visits	Standard Deductible	Standard Deductible and Coinsurance, plus any balances**
Services of a surgeon, operating room for surgery and anesthesia		
Provider and professional services for the delivery of a baby Provider 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)		
Emergency Room Visits and Urgent Care Facility Visits		
Use of the emergency room	Standard Deductible	Standard Deductible and Coinsurance, plus any balances††
Use of an Urgent Care Facility		
Provider(s) fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs		
Laboratory and x-ray tests		
Ambulance Services		
Medically Necessary ambulance transport	Standard Deductible	
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy 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 • **Office visit** – Unlimited Medically Necessary visits		
• **X-ray tests** furnished by a chiropractor		
Acupuncture – Unlimited Medically Necessary visits by a provider or licensed acupuncturist		
Early Intervention Services	Standard Deductible	
IV. Home Care		
Provider services 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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† Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

†† 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.

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	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Use Care)		
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.	Standard Deductible	Standard Deductible and Coinsurance, plus any balances**
Partial Hospitalization and Outpatient Treatment		
Mental Disorders: Unlimited Medically Necessary care **Substance Use Disorders:** Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible	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	Standard Deductible	Standard Deductible and Coinsurance, plus any balances**
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. As required by law, "Preventive Care" pharmacy services are covered in full when furnished by a Network Pharmacy with a prescription from Your provider. In addition, as permitted by IRS Notice 2019-45, covered prescription insulin drugs for individuals diagnosed with diabetes are not subject to any Standard Deductible and/or Standard Coinsurance, but are subject to cost sharing of up to $30 for each 30-day supply.		

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** 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.