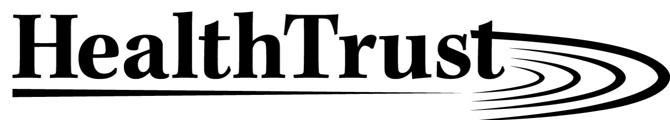

## BlueChoice®
## Cost Sharing Schedule

*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<br>*When Your PCP provides or refers Your care* | Option 2<br>*When You seek care directly from a Network Provider* | Option 3*<br>*When You seek care directly from an Out-of-Network Provider* |
|---|---|---|---|
| | **YOUR COST** | | |
| **Visit Copayment**<br>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**<br>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<br>$450 per family, per year |
| **Standard Coinsurance** | N/A | 20% | 20% |
| **Coinsurance Maximum** | N/A | $600 per Member, per year<br>$1,800 per family, per year | $900 per Member, per year<br>$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<br>$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 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.

**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.**

<table>
<tr><th rowspan="2">Coverage Outline</th><th>Option 1<br>When Your PCP provides or refers Your care</th><th>Option 2<br>When You seek care directly from a Network Provider</th><th>Option 3*<br>When You seek care directly from an Out-of-Network Provider</th></tr>
<tr><th colspan="3">YOUR COST</th></tr>
<tr><td colspan="4">I. Inpatient Services</td></tr>
<tr><td>In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)</td><td rowspan="4">You pay $0</td><td rowspan="4">Standard Coinsurance</td><td rowspan="4">Standard Deductible and Coinsurance, plus any balances</td></tr>
<tr><td>In a Skilled Nursing Facility (Facility charges)</td></tr>
<tr><td>In a Physical Rehabilitation Facility (Facility charges)</td></tr>
<tr><td>Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)</td></tr>
<tr><td colspan="4">II. Outpatient Services</td></tr>
<tr><td colspan="4">Preventive Care</td></tr>
<tr><td>Preventive Care and screenings as required by law or permitted by the Plan including, but not limited to:<br>-Routine physical exams for babies, children and adults (including one annual gynecological exam†)<br>-Immunizations for babies, children and adults (including travel and rabies immunizations)<br>-Cancer screenings such as mammograms, pap smears, prostate-specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy<br>-Lead screening<br>-Outpatient/office contraceptive services<br>-Nutrition counseling<br>-Diabetes management program^<br>-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.†<br>-Routine hearing exams - one exam each year.†</td><td>You pay $0</td><td>You pay $0</td><td>Standard Deductible and Coinsurance, plus any balances</td></tr>
<tr><td colspan="4">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</td></tr>
<tr><td>Medical exams, telemedicine and online visits, consultations, and medical treatments</td><td>Visit Copayment or Specialty Visit Copayment</td><td>Visit Copayment or Specialty Visit Copayment</td><td rowspan="9">Standard Deductible and Coinsurance, plus any balances</td></tr>
<tr><td>Injections (except allergy injections)</td><td rowspan="8">You pay $0</td><td rowspan="6">You pay $0</td></tr>
<tr><td>Allergy injections</td></tr>
<tr><td>Office surgery (including anesthesia)</td></tr>
<tr><td>Surgery and anesthesia</td></tr>
<tr><td>Laboratory tests (including allergy testing)</td></tr>
<tr><td>X-ray tests (including ultrasound)</td></tr>
<tr><td>MRA, MRI, PET, SPECT, CT Scan and CTA</td><td rowspan="2">Standard Coinsurance</td></tr>
<tr><td>Medical supplies (including hearing aids), chemotherapy, infusion therapy, and drugs</td></tr>
<tr><td>Provider services at a Walk-In Center or Retail Health Clinic</td><td colspan="3">Walk-In Center Copayment</td></tr>
<tr><td>Maternity care (prenatal and postpartum visits)<br>Please see your Subscriber Certificate for information about maternity care.</td><td colspan="3">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.”</td></tr>
</table>

* 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.

† 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.

| | Option 1<br>*When Your PCP provides or refers Your care* | Option 2<br>*When You seek care directly from a Network Provider* | Option 3*<br>*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<br>Physician and professional services for the delivery of a baby<br>Physician and professional services for management of therapy<br>Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA<br>Fees for use of a facility, medical supplies (including hearing aids), drugs, other ancillaries, observation | You pay $0 | Standard Coinsurance | |
| Laboratory and x-ray tests (including ultrasounds) | | You pay $0 | |
| **Emergency Room Visits and Urgent Care Facility Visits** | | | |
| Use of the emergency room<br>(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<br>Laboratory and x-ray tests | You pay $0 | You pay $0 | Standard Deductible and Coinsurance, plus any balances |
| **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**<br>**Chiropractic Care^**<br>• **Office visit** - unlimited | Specialty Visit Copayment | Specialty Visit Copayment | |
| • **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**<br>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**<br>**Hospice**<br>**Infusion Therapy** | You pay $0 | Standard Coinsurance | |
| **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 see 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.

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

| | Option 1<br>*When You seek care directly from a Network Provider* | Option 3*<br>*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<br><br>**Substance Use Care Visits:** Unlimited Medically Necessary visits (including detoxification and substance use rehabilitation services)<br><br>**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<br><br>**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:**<br>Unlimited Medically Necessary Inpatient days<br><br>**Substance Use Disorders:**<br>• Medical detoxification days - Unlimited Medically Necessary Inpatient days<br>• 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. | | |

* 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.

^ 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.