BC/BS HMO $1500

Anthem BlueCross BlueShield

Access Blue New England

Cost Sharing Schedule

This Cost Sharing Schedule is an important part of your Subscriber Certificate. Please keep this schedule with your Certificate, because it contains important information about coverage and limitations.

Cost Sharing Summary	YOUR COST* *Benefits are limited to the Maximum Allowable Benefit*
Visit Copayment Applies each time you visit your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist	$20 per visit
Specialty Visit Copayment Applies each time you visit a specialist who is not your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist. This Copayment also applies each time you visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$30 per visit
Urgent Care Facility Copayment Applies each time you visit a licensed hospital's urgent care facility in the Network for diagnosis, care and treatment of illness or injury.	$50 per visit
Emergency Room Copayment	$100 per visit
Inpatient Copayment	$1,500 per admission
Outpatient Surgery Copayment	$1,500 per admission
Inpatient Copayment and Outpatient Surgery Copayment (combined) Maximum	$1,500 per Member, per Contract Year $3,000 per family, per Contract Year
Out-of-Pocket Limit The Out-of-Pocket Limit includes all Copayments you pay during a Contract Year. It does not include your premium, amounts over the Maximum Allowable Benefit, or charges for noncovered services. Once the Out-of- Pocket Limit is satisfied, you will not have to pay additional Copayments for the rest of the Contract Year.	$6,350 per Member, per Contract Year $12,700 per family, per Contract Year

Pharmacy Benefit Cost Sharing
You may purchase up to a 90-day supply of a covered prescription drug at one time, provided that the drug is a Covered Service, the quantity is ordered by your physician and the drug does not require Precertification from Anthem.

- You pay one Copayment for each prescription filled (or refilled) up to a 30-day supply.
- At a retail pharmacy, you pay two Copayments for a supply of 31 to 60 days and three Copayments for supplies of 61 to 90 days.
- At a mail order pharmacy, you pay two Copayments for a 31 to 90 day fill or refill.

Please see your Pharmacy Rider for complete information about your share of the cost for Covered Services purchased at a pharmacy.

At a Retail Pharmacy or by Mail Order:	Your Cost
Tier 1 Prescription Drug Copayment	$10
Tier 2 Prescription Drug Copayment	$30
Tier 3 Prescription Drug Copayment	$50

*Benefits are limited to the Maximum Allowable Benefit. If you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and charge.

The following is an outline of your coverage. Do not rely on this outline alone. Please read your Subscriber Certificate carefully, because important terms and limitations apply.

Coverage Outline	Your Cost*
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Inpatient Copayment per admission
In a Skilled Nursing Facility (Facility charges) - Up to 100 Inpatient days per Member, per Calendar Year	
In a Physical Rehabilitation Facility (Facility charges) - Up to 100 Inpatient days per Member, per Calendar Year	
Inpatient Physician and Professional Services Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests (For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.)	You pay $0
II. Outpatient Services	
Preventive Care	
Preventive care and screenings as required by law including, but not limited to: Immunizations for babies, children and adults Cancer screenings such as mammograms and pap smears, routine colonoscopy and sigmoidoscopy screening including fecal occult blood tests, barium enema, and related prep kit and CT colonography (as appropriate) Routine physical exams for babies, children and adults, including an annual gynecological exam Routine hearing and vision screenings and other preventive care and screenings for infants, children, adolescents and women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration Lead screening and any other screening with an "A" or "B" rating from the United States Preventive Services Task Force including, but not limited to: screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, child and adult obesity Outpatient/office contraceptive services as required by law Nutrition counseling including nutrition counseling for eating disorders	You pay $0
Other preventive care: Travel and rabies immunizations Prostatic specific antigen (PSA) screening	You pay $0
Routine hearing exams	You pay $0

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Coverage Outline	Your Cost*
Other preventive care (continued)	
Routine vision exams One exam each Contract Year for Members 18 years old and younger; One exam every two Contract Years for Members 19 years old and older	You pay $0
Prescription Eyewear - Anthem covers $100 per Member every other Contract Year toward the cost of prescription eyewear (frames, lenses and contact lenses).	You pay any amount that exceeds Anthem's $100 allowance.
Diabetes management program	You pay $0
Medical/Surgical Care in a Physician's Office (in addition to the Preventive Care above)	
Medical exams, consultations, office surgery and anesthesia, medical treatments, telemedicine visits and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Laboratory and x-ray tests (including allergy testing and ultrasound)	
MRI, CT Scan, chemotherapy, medical supplies and drugs	
Contraceptive drugs and devices that must be administered in a provider's office (such as IUDs)	
Maternity care (prenatal and postpartum visits) Please see your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment or Specialty Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).
Outpatient Facility Care in the Outpatient Department of a Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center (in addition to the Preventive Care above)	
Medical exams and consultations by a physician and telemedicine visits	Visit Copayment or Specialty Visit Copayment
Operating room for surgery or delivery of a baby	Outpatient Surgery Copayment per admission
Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRI, CT Scan, Facility charges, medical supplies, drugs, other ancillaries, observation	You pay $0
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room at a Network or Out-of-Network* Hospital (The Copayment is waived if you are admitted)	Emergency Room Copayment*
- Emergency room physician's fee, surgery, laboratory and x-ray tests, MRI, CT Scan, medical supplies and drugs	You pay $0*
Use of a licensed hospital Urgent Care Facility in the Network	Urgent Care Facility Copayment
- Urgent Care Facility physician's fee, surgery, laboratory and x-ray tests, MRI, CT Scan, medical supplies and drugs	You pay $0
Ambulance Services – Network or Out-of-Network* Services Transport by ambulance must be Medically Necessary. .	You pay $0*

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Coverage Outline	Your Cost*
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy (Up to a combined maximum of 60 therapy visits per Member, per Contract Year)	You pay $0
Cardiac Rehabilitation Visits	Specialty Visit Copayment
Chiropractic Care • Office Visits	
• Laboratory and x-ray tests furnished by a chiropractor	You pay $0
Early Intervention Services Available from birth to a covered child's third birthday.	Specialty Visit Copayment
IV. Home Care (in addition to the Preventative Care listed in subsection II above)	
Physician Services Medical exams and routine physical exams for babies, children and adults, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Home Health Agency Services	
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	You pay $0
V. Behavioral Health Care (Mental Health and Substance Use Care)	
Outpatient/Office Visits and Telemedicine Visits **Mental Health Visits** - Unlimited Medically Necessary visits **Substance Use Visits** (including detoxification and substance use rehabilitation) - Unlimited Medically Necessary visits	$20 Copayment each visit
Partial Hospitalization and Intensive Outpatient Treatment Programs **Mental Disorders** - Unlimited Medically Necessary care **Substance Use Disorders** - Unlimited Medically Necessary care for rehabilitation	You pay $0
Inpatient Care **Mental Disorders** - Unlimited Medically Necessary Inpatient days **Substance Use Disorders** (including detoxification and substance use rehabilitation) - Unlimited Medically Necessary Inpatient days	Inpatient Copayment per admission
Scheduled Ambulance Transport - Network or Out-of-Network* Services Transport by ambulance must be Medically Necessary.	You pay $0*

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