Anthem BlueCross BlueShield

BlueChoice® 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	Network Benefits	Out-of-Network Benefits *Benefits are limited to the Maximum Allowable Benefit**
Visit Copayment	$25 per visit	Copayment is not applicable
Specialty Visit Copayment - Applies each time you visit a specialist who is not your Primary Care Provider (PCP). This Copayment also applies each time you visit a Network Physician at a walk-in center for diagnosis, care and treatment of an illness or injury.	$35 per visit	Copayment is not applicable
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.	$75 per visit	$75 per visit
Emergency Room Copayment	$150 per visit	$150 per visit
Inpatient Copayment	$1,500 per admission	Copayment is not applicable
Outpatient Surgical Copayment	$1,500 per admission	Copayment is not applicable
Inpatient Copayment and Outpatient Surgery Copayment (combined) Maximum	$1,500 per Member, per Contract Year $3,000 per family, per Contract Year	Copayment is not applicable
Standard Deductible	not applicable	$1,500 per Member, per Contract Year $3,000 per family, per Contract Year
Standard Coinsurance	not applicable	20%
Coinsurance Maximum	not applicable	$400 per Member, per Contract Year $1,200 per family, per Contract Year
Out-of-Pocket Limit Includes all Deductibles, Coinsurance, and 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 Deductibles, Coinsurance, or Copayments for the rest of the Contract Year.	$6,350 per Member, per Contract Year $12,700 per family, per Contract Year	$1,900 per Member, per Contract Year $4,200 per family, per Contract Year
Inpatient Precertification Penalty	Not applicable	$500

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

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. At a retail pharmacy, you pay more than one Copayment for any fill or re-fill that exceeds a 30-day supply. At the mail order pharmacy, you pay one Copayment for any fill or re-fill up to a 90-day supply. Please see your Pharmacy Rider for complete information.

At a Retail Pharmacy:	
Tier 1 Copayment	$10
Tier 2 Copayment	$30
Tier 3 Copayment	$50
By Mail Order:	
Tier 1 Copayment	$20
Tier 2 Copayment	$60
Tier 3 Copayment	$100

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Coverage Outline

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.

Medical/Surgical Care	Network Benefits	Out-of-Network Benefits*
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Inpatient Copayment	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility and/or Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per Calendar Year†	Inpatient Copayment	
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, Lead-screening,	You pay $0	You pay any balances
Routine physical exams for babies, children and adults, including an annual gynecological exam Cancer screenings such as routine colonoscopy and sigmoidoscopy screening including fecal occult blood tests, barium enema, and related prep kit and CT colonography (as appropriate) 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 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	Standard Deductible and Coinsurance, plus any balances
Other preventive care: Travel and rabies immunizations Prostatic specific antigen (PSA) screening	You pay $0	
Routine vision exams - one exam each Calendar Year for Members 18 years old and younger; one exam every two Calendar Years for Members 19 years old and older † Routine hearing exams	You pay $0	
Diabetes management program	You pay $0	

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† Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

Coverage Outline	Network Benefits	Out-of-Network Benefits*
Medical/Surgical Care in a Physician's Office (in addition to the Preventive Care above)		
Medical exams, consultations, office surgery and anesthesia, telemedicine visits, medical treatments, including physician services at a Network Walk-In Center.	Visit Copayment or Walk-In Center Copayment	Standard Deductible and Coinsurance, plus any balances
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 for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" and "Outpatient Facility Care."	
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	Standard Deductible and Coinsurance, plus any balances
Operating room for surgery or delivery of a baby	Outpatient Surgery Copayment	
Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRI, CT Scan, laboratory and x-ray tests (including ultrasounds) Facility charges, medical supplies, drugs, other ancillaries, observation	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	Same as Network Benefits*
Emergency room physician's fee, surgery, MRI, CT Scan, medical supplies and drugs, laboratory and x-ray tests	You pay $0	Same as Network Benefits*
Use of a licensed hospital Urgent Care facility in the Network	Urgent Care Facility Copayment	Same as Network Benefits*
Urgent care facility physician's fee, surgery, MRI, CT Scan, medical supplies and drugs, laboratory and x-ray tests	You pay $0	Same as Network Benefits*
Ambulance Services - Transport by ambulance must be Medically Necessary.	You pay $0	Same as Network Benefits*
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy	You pay $0	Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Specialty Visit Copayment	
Chiropractic Care • Office Visits (Limited to 12 visits per Member, per Contract Year) †		
• 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.	Visit Copayment	

Coverage Outline	Network Benefits	Out-of-Network Benefits*
IV. Home Care (in addition to the Preventative Care listed in subsection II above)		
Physician Services - Medical exams for babies, children and adults, telemedicine visits, medical treatments, surgery and anesthesia	Visit Copayment	Deductible and Coinsurance, plus any balances
Home Health Agency Services	You pay $0	
Hospice		
Infusion Therapy		
Durable Medical Equipment and Medical Supplies		

V. Behavioral Health Care (Mental Health and Substance Abuse Care)

Network Benefits are available when you receive Covered Services from an Eligible Behavioral Health Provider.
Self Referred Benefits are available when you obtain Covered Services from any Out-of-Network Eligible Behavioral Health Provider.

Coverage Outline	Network Benefits	Out-of-Network Benefits*
Outpatient/Office Visits and Telemedicine Visits		
Mental Health Visits – Medically Necessary visits. **Substance Abuse Visits** - Medically Necessary visits (Including detoxification and substance abuse rehabilitation)	Visit Copayment each visit	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.	You pay $0	Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders – Medically Necessary Inpatient days Substance Abuse Conditions – unlimited Medically Necessary Inpatient days (including detoxification and substance abuse rehabilitation)	Inpatient Copayment per admission	Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport - Limited to Medically Necessary transport from one facility to another	You pay $0	Same as Network Benefits

VI. Prescription Eyewear

Benefits are limited to a maximum of $100 per Member every two year. Please refer to your Prescription Eyewear Rider in your Certificate for more information.

VII. Fitness Club Reimbursement

Limited to a $200 maximum per household per Contract Year.

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