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 a Preferred Provider or Preferred obstetrical/gynecological specialist.	N/A	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Walk-In Center for diagnosis, care and treatment of an illness or injury.	N/A	
Emergency Room Copayment	N/A	
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's urgent care facility for diagnosis, care and treatment of an illness or injury.	N/A	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	Standard Deductible	Standard Deductible
Coinsurance	N/A	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 and Your HealthTrust prescription benefit program. 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 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.

+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 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	
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions) **In a Skilled Nursing Facility** (Facility charges) Up to 100 Inpatient days per Member, per year† **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) Skilled Nursing Facility admissions are limited to the number of Inpatient days stated above.	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law or permitted by the Plan including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as, mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -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 Physician's Office or Walk-In Center 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 Preferred Provider services at a Network Walk-In Center Injections (except allergy injections) Allergy injections Office surgery (including anesthesia) Laboratory tests (including allergy testing) X-ray tests (including ultrasound) MRA,MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
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.

	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 physician, telemedicine and online visits	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia		
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, 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 a licensed hospital's urgent care facility		
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs		
Laboratory and x-ray tests		
Ambulance Services Medically Necessary Emergency 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**		
• **X-ray tests** furnished by a chiropractor		
Acupuncture - Up to 12 visits per Member, per year by a physician or licensed acupuncturist		N/A
Early Intervention Services		Standard Deductible and Coinsurance, plus any balances
IV. Home Care		
Physician 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.

	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Network Benefits are available when You obtain Covered Services from a Preferred Provider, as approved in advance. **Out-of-Network Benefits** are available when You obtain Covered Services from any Eligible Mental Health or Substance Abuse Provider, as approved in advance.		
Outpatient/Office/Telemedicine/Online Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions:** 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 Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation - Unlimited Medically Necessary Inpatient days	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	Standard Deductible	
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.		

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.healthtrustnh.org or call 1-800-527-5001. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-224-4896 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** individual/**$5,000** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, preventive care is not subject to the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive servicesat https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For **network** benefits: **$2,500** individual/**$5,000** family. For out-of-network benefits: **$5,000** individual/**$10,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. Lumenos. See www.anthem.com or call 1-888-224-4896 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	--------none--------
	Specialist visit	0% coinsurance	30% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-224-4896** or **www.anthem.com**.	Generic drugs	0% coinsurance	30% coinsurance	Coinsurance after deductible applies to retail and mail service. Covers up to a 90 day supply retail and mail service.
	Preferred brand drugs	0% coinsurance	30% coinsurance	
	Non-preferred brand drugs	0% coinsurance	30% coinsurance	
	Specialty drugs	0% coinsurance	30% coinsurance	--------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	0% coinsurance	30% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	0% coinsurance	30% coinsurance	--------none--------
	Emergency medical transportation	0% coinsurance	30% coinsurance	--------none--------
	Urgent care	0% coinsurance	30% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	0% coinsurance	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	--------none--------
	Inpatient services	0% coinsurance	30% coinsurance	--------none--------
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	--------none--------
	Rehabilitation services	0% coinsurance	30% coinsurance	Coverage for physical, speech and occupational therapy services is limited to 60 combined visits per member per year.
	Habilitation services	0% coinsurance	30% coinsurance	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	30% coinsurance	Maximum of 100 days per member per year.
	Durable medical equipment	0% coinsurance	30% coinsurance	--------none--------
	Hospice services	0% coinsurance	30% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	0% coinsurance	30% coinsurance	Limited to one exam per year.
	Children's glasses	Not covered	Not covered	--------none--------
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (limited to one hearing aid per ear each time a prescription changes)
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ciio.cms.gov.
Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2500**
- **Specialist copayment** **$0**
- **Hospital (facility) *coinsurance*** **0%**
- **Other *coinsurance*** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2500**
- **Specialist copayment** **$0**
- **Hospital (facility) *coinsurance*** **0%**
- **Other *coinsurance*** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drug
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$134
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$21
The total Joe would pay is	**$155**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2500**
- **Specialist copayment** **$0**
- **Hospital (facility) *coinsurance*** **0%**
- **Other *coinsurance*** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1074
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1074**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.