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 Preferred Physician at a Preferred 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 Preferred 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** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, amounts over the Maximum Allowable Benefit or charges for noncovered services.	$2,500 per Member, per year $5,000 per family, per year	$5,000 per Member, per year $10,000 per family, per year
Inpatient Precertification Penalty	N/A	N/A

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAB 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.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

+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 calendar year.

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)	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) Up to 100 Inpatient days per Member, per 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.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law 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 -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, consultations, anesthesia, medical treatments, and Preferred Provider services at a Network Walk-In Center	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Injections (including allergy injections)		
Office surgery		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA,MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total 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	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**		
• **Laboratory and x-ray tests** furnished by a chiropractor		
Early Intervention Services		
IV. Home Care		
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Home Health Agency services – Up to 100 visits per Member, per year†		
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics		

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	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 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		
not applicable		
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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