HMO 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
Lifetime Maximum	Unlimited per Member's lifetime
Visit Copayment Applies each time you visit your Primary Care Provider (PCP) or Network Obstetrician/Gynecologist specialist.	$[redacted] per visit
Specialty Visit Copayment Applies each time you visit a Specialist who is not your Primary Care Provider (PCP) or Network Obstetrician/Gynecologist specialist. This Copayment also applies each time you visit a Network Physician at a Network Walk-In Center in the Service Area for diagnosis, care and treatment of an illness or injury.	$[redacted] per visit
Emergency Room Copayment	$[redacted] 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.	$[redacted] per visit
Standard Deductible	$[redacted] per Member, per year $[redacted] per family, per year
Medical Equipment, Medical Supplies and Prosthetics	Standard Deductible
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 may be required to pay more than one Copayment for any fill or re-fill that exceeds a 30-day supply. 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:	
Tier 1 Copayment	$[redacted]
Tier 2 Copayment	$[redacted]
Tier 3 Coinsurance	[redacted]%
By Mail Order:	
Tier 1 Copayment	$[redacted]
Tier 2 Copayment	$[redacted]
Tier 3 Coinsurance	[redacted]%
Coinsurance maximum	$[redacted] per Member, per Calendar Year $[redacted] per Family, per Calendar Year

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.

Coverage Outline	Your Cost
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
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 60 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.)	
II. Outpatient Services	
Preventive Care	
Immunizations for babies, children and adults (Including travel and rabies immunizations) Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening	You pay $[redacted]
Routine physical exams for babies, children and adults (Including one annual gynecological exam) Family planning visits Nutrition counseling Routine vision exams One exam every two Calendar years Routine hearing exams	
Diabetes management program	Standard Deductible
Medical/Surgical Care in a Physician's Office, or at an Independent Ambulatory Surgical Center, or Independent Laboratory Provider (in addition to the Preventive Care above)	
Medical exams, consultations, medical treatments, including physician services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	
Office surgery and anesthesia	
Surgery and anesthesia at an independent ambulatory surgical center in the Network	$[redacted] per admission
Laboratory tests (including allergy testing)	You pay $[redacted]
X-ray tests (including ultrasound)	Standard Deductible
MRI, CT Scan, chemotherapy, medical supplies and drugs	

Coverage Outline	Your Cost
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, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center (in addition to the Preventive Care above)	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Operating room for surgery or delivery of a baby	Standard Deductible
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	
Laboratory and x-ray tests (including ultrasounds)	
Also, see III, "Outpatient Physical Rehabilitation Services" (below)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	
Ambulance Services Transport by ambulance must be Medically Necessary.	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy Up to 20 visits per Member, per Calendar Year.	Specialty Visit Copayment
Occupational Therapy Up to 20 visits per Member, per Calendar Year.	
Speech Therapy Up to 20 visits per Member, per Calendar Year.	
Cardiac Rehabilitation Visits	
Chiropractic Care • Office Visits	
• Laboratory and x-ray tests furnished by a chiropractor	Standard Deductible
Early Intervention Services Available from birth to a covered child's third birthday. Limited to $3,200 per Member, per Calendar Year and $9,600 by the child's third birthday. *Please see Section 7, "Covered Services," III in your Certificate for complete information about Benefits for Early Intervention Services for children with Developmental Disabilities or delays. Coverage is provided as required under NH law*	Specialty Visit Copayment

Coverage Outline	Your Cost
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,	Visit Copayment or Specialty Visit Copayment
Injections	
Surgery and anesthesia	
Home Health Agency Services	Standard Deductible
Hospice	You Pay $[redacted]
Infusion Therapy	Standard Deductible
Medical Equipment, Medical Supplies and Prosthetics	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits Unlimited Medically Necessary visits Two office visits for diagnosis and three treatment visits are allowed each Contract year without clinical review.	Visit Copayment each visit
Substance Abuse Visits (Including detoxification and substance abuse rehabilitation combined) Unlimited Medically Necessary visits	
Inpatient Care	
All Behavioral Health Care described below must be preauthorized by Anthem. Call 1-800-228-5975 for Preauthorization. Please see Section 7 "Covered Services," V in your Subscriber Certificate for details.	
Mental Disorders: Unlimited Medically Necessary Inpatient days, as approved by Anthem's Preauthorization	Standard Deductible
Substance Abuse Conditions: • Medical detoxification days – Medically Necessary Inpatient days as approved by Anthem's Preauthorization. • Substance Abuse Rehabilitation – as approved by Anthem's Preauthorization.	
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care, as approved by Anthem's Preauthorization	Standard Deductible
Substance Abuse Conditions: Medically Necessary Preauthorized care for rehabilitation.	
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	