Matthew Thornton Blue[SM]

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
Visit Copayment Applies each time you visit your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$[redacted] 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.	$[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 Calendar Year $[redacted] per family, per Calendar Year
Durable Medical Equipment, Supplies and Prosthetics	
Deductible	$[redacted] per Member, per Calendar Year
Coinsurance	[redacted]%
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 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.	
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 each Calendar Year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.) Routine hearing exams (One exam each Calendar Year for Members 18 years old and younger.)	
Diabetes management program	Standard Deductible
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 (in addition to the Preventive Care above)	
Medical exams, consultations, medical treatments, telemedicine visits and Network Provider 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	$[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 above for "Inpatient Services" or below under "Outpatient Facility Care".
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 and telemedicine visits	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)	
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, MRI, CT Scan, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	
Ambulance Services Limited to Medically Necessary emergency transport	
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 – Up to 12 visits per Member, per Calendar Year	
• 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, telemedicine visits	Visit Copayment or Specialty Visit Copayment
Injections	
Surgery and anesthesia	
Home Health Agency Services	Standard Deductible
Hospice	You Pay $[redacted]
Infusion Therapy	Standard Deductible
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits, Telemedicine visits	
Mental Health Visits Unlimited Medically Necessary visits A minimum of two visits for diagnosis and three treatment visits are allowed each without clinical review.	Visit Copayment each visit
Substance Abuse Visits Unlimited Medically Necessary visits	
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders Unlimited Medically Necessary care	Standard Deductible
Substance Abuse Conditions: Medically Necessary care for rehabilitation	
Inpatient Care	
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. • Substance Abuse Rehabilitation – Medically Necessary Inpatient days.	
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	