



LUMENOS[®] Health Savings Account (HSA) - BlueChoice[®] New England with HSA 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	
	Network Benefits <i>Benefits are limited to the Maximum Allowable Benefit*</i>	Out-of-Network Benefits <i>Benefits are limited to the Maximum Allowable Benefit*</i>
Standard Deductible If you have a single membership, the Deductible amount is: If you have a family membership, the Deductible amount is:	\$2,000 per Member, per Contract Year \$4,000 per family, per Contract Year	
Standard Coinsurance Coinsurance Maximum If you have a single membership, the Coinsurance Maximum is: If you have a family membership, the Coinsurance Maximum is:	not applicable	30% \$2,000 per Member, per Contract Year \$4,000 per family, per Contract Year
Out of Pocket Limit If you have a single membership, the Out-of-Pocket Limit is: If you have a family membership, the Out-of-Pocket Limit is:	\$2,000 per Member, per Contract Year \$4,000 per family, per Contract Year	\$4,000 per Member, per Contract Year \$8,000 per family, per Contract Year
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 Prerertification from Anthem. 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 or by Mail Order -	Deductible applies	Deductible and Coinsurance apply

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

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

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	
	Network Benefits*	Out-of-Network Benefits*
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 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		
Preventive Care services include, but are not limited to: Immunizations for babies, children and adults Cancer screenings such as mammograms and pap smears, Lead-screening, 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 and “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

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Coverage Outline	Your Cost	
	Network Benefits*	Out-of-Network Benefits*
Other preventive care: Travel and Rabies immunizations Prostatic specific antigen (PSA) screening	You pay \$0	Standard Deductible and Coinsurance, plus any balances
Routine hearing exams Routine vision exams (One exam per Member, per Calendar Year)		
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, or Independent Infusion Therapy Provider, or Independent Laboratory Provider or Independent Radiology Provider (in addition to the Preventive Care above)		
Medical exams, consultations, office surgery and anesthesia, injections (including allergy injections), medical treatments, telemedicine visits and physician services at a Walk-In Center	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Laboratory and x-ray tests (including allergy testing and ultrasound)		
MRA, MRI, PET, SPECT, CT Scan, CTA Chemotherapy, drugs, medical supplies, including one hearing aid per ear each time a hearing aid prescription changes		
Contraceptive drugs and devices that must be administered in a provider's office (such as IUDs)	You pay \$0	
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 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, or a Short Term General Hospital's Hemodialysis Center or a Birthing Center (in addition to the Preventive Care above)		
Medical exams and consultations by a physician and telemedicine visits	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Operating room for surgery or delivery of a baby		
Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy		
Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA		
Facility charges, drugs, medical supplies, 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*	Same as Network Benefits*
Emergency room physician's fee, surgery, laboratory and x-ray tests, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs.		

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Coverage Outline	Your Cost	
	Network Benefits*	Out-of-Network Benefits*
Use of a licensed hospital urgent care facility Physician's fee, surgery, laboratory and x-ray tests, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Ambulance Services Transport by ambulance must be Medically Necessary.	Standard Deductible*	Same as Network Benefits*
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy (Up to a combined maximum of 60 visits per Member, per Contract Year [†])	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits		
Early Intervention Services Available from birth to a covered child's third birthday.		
Chiropractic Care <ul style="list-style-type: none"> Office Visits (Up to 12 visits per Member, per Contract Year[†]) Laboratory and x-ray tests furnished by a chiropractor 		
IV. Home Care (in addition to the Preventive Care listed in subsection II above)		
Physician Services Medical exams, injections, medical treatments, surgery and anesthesia and telemedicine visits	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services (Up to 100 visits per Member, per Calendar Year [†])		
Hospice		
Infusion Therapy		
Medical Equipment, Medical Supplies and Prosthetics		

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Coverage Outline	YOUR COST	
	Network Benefits*	Out-of-Network Benefits*
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
<p>To receive Network Benefits, you must obtain Covered Services from an Eligible Mental Health or Substance Abuse Provider in the Network. Out-of-Network Benefit, are available when you obtain Covered Services from any Out-of-Network Eligible Mental Health or Substance Abuse Provider.</p>		
Outpatient/office visits and telemedicine visits		
Mental Health Visits - Unlimited Medically Necessary visits. Substance Abuse Visits - (Including detoxification and substance abuse rehabilitation) – Unlimited Medically Necessary visits	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 - Unlimited Medically Necessary care for rehabilitation.	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: - Unlimited Medically Necessary Inpatient days. Substance Abuse Conditions: Unlimited Medically Necessary Inpatient days.(includes detoxification and substance abuse rehabilitation) –	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport - Limited to Medically necessary transport from one facility to another.	Standard Deductible*	Same as Network Benefits*

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