



Matthew Thornton BlueSM 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 | YOUR COST |
|---|---|
| Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist. | \$15 per visit |
| Specialty Visit Copayment Applies each time You visit a 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. | \$15 per visit |
| Emergency Room Copayment | \$100 per visit |
| Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury. | \$50 per visit |
| Standard Deductible | \$500 per Member, per year \$1,500 per family, per year |
| Standard Coinsurance | not applicable |
| Coinsurance Maximum | |
| Durable Medical Equipment, Medical Supplies and Prosthetics Deductible Coinsurance | \$100 per Member, per year 20% |
| Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services. | \$6,350 per Member, per year \$12,700 per family, per year |

*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.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline

YOUR COST

Medical/Surgical Care

I. Inpatient Services

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| 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 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

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| 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 - One exam each 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 year for Members 18 years old and younger. | You pay \$0 |
|---|-------------|

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

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| Medical exams, consultations, anesthesia, medical treatments, and Network Provider services at a Network Walk-In Center | Visit Copayment or Specialty Visit Copayment |
| Injections (including allergy injections) | You pay \$0 |
| Office surgery | |
| Laboratory tests (including allergy testing) | |
| X-ray tests (including ultrasound) | |
| MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs | Standard Deductible |
| Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about total maternity care. | You pay no 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). |

| YOUR COST | |
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| 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 | Visit Copayment or Specialty Visit Copayment |
| Services of a surgeon, operating room for surgery and anesthesia | You pay \$0 |
| Physician and professional services for 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 | Standard Deductible |
| Laboratory and x-ray tests (including ultrasounds) | You pay \$0 |
| 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's 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 | You pay \$0 |
| Ambulance Services Transport by ambulance must be Medically Necessary | 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 | Visit Copayment or Specialty Visit Copayment |
| Cardiac Rehabilitation Visits | |
| Chiropractic Care <ul style="list-style-type: none"> • Office visits - up to 12 visits per Member, per year • Laboratory and x-ray tests furnished by a chiropractor | |
| Early Intervention Services | Visit Copayment or Specialty Visit Copayment |
| IV. Home Care | |
| Physician services Medical exams, injections, medical treatments, surgery and anesthesia | Visit Copayment or Specialty Visit Copayment |
| Home Health Agency services | Standard Deductible |
| Hospice | |
| Infusion Therapy | |
| Durable Medical Equipment, Medical Supplies and Prosthetics | Subject to the DME Deductible and Coinsurance |

| YOUR COST | |
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| V. Behavioral Health Care (Mental Health and Substance Abuse Care) | |
| Outpatient/Office Visits | |
| Mental Health Visits: Unlimited Medically Necessary visits Substance Abuse Visits: Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services) | Visit Copayment or Specialty Visit Copayment |
| Partial Hospitalization and Intensive Outpatient Treatment Programs | |
| Mental Disorders: Unlimited Medically Necessary care Substance Abuse Conditions: Unlimited Medically Necessary care for rehabilitation and detoxification | Standard Deductible |
| Inpatient Care | |
| Mental Disorders: Unlimited Medically Necessary Inpatient days Substance Abuse Conditions: <ul style="list-style-type: none"> • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days | Standard Deductible |
| Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another | |
| VI. Prescription Eyewear | |
| Benefits are limited to a maximum of \$40 per Member, per year. Please refer to your Prescription Eyewear Rider for more information. | |