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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%

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

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 year	Standard Deductible
In a Physical Rehabilitation Facility (Facility charges) up to 100 Inpatient days per Member, per year	Standard Deductible
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.	Standard Deductible
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 \$0
Routine physical exams for babies, children and adults (including one annual gynecological exam) Family planning visits 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
Diabetes management program	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	
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	You pay \$0
Laboratory tests (including allergy testing)	You pay \$0
X-ray tests (including ultrasound)	You pay \$0
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	
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	Visit Copayment or Specialty Visit Copayment
Chiropractic Care • Office visits - up to 12 visits per Member, per year • Laboratory and x-ray tests furnished by a chiropractor	Visit Copayment or Specialty Visit Copayment You pay \$0
Early Intervention Services Available from birth to a covered child's third birthday. Limited to \$3,200 per Member per year and \$9,600 by the child's third birthday.	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	Standard Deductible
Infusion Therapy	Standard Deductible
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits, Partial Hospitalization, and Intensive Outpatient Treatment Programs	
Mental Health visits - Unlimited Medically Necessary visits	Visit Copayment or Specialty Visit Copayment
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	Standard Deductible
Substance Abuse Conditions: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days	Standard Deductible
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	Standard Deductible
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.	