School Administrative Unit #01

HealthTrust		BlueChoice POS Plan (BC3T10)			Access Blue (AB15IPDED)	Access Blue Site of Service (ABSOS20/40/1KDED)
		When Your PCP provides or refers Your care	When You seek care directly from a BlueChoice provider	When You seek care from any out-of-network provider (1)	Network Benefits (2)	Network Benefits (2)
Cost Sharing	Visit Copayment	$10 per visit	$30 per visit	N/A	$15 per visit	$20 per visit
	Specialty Visit Copayment	$10 per visit	$30 per visit	N/A	$15 per visit	$40 per visit
	Walk-In Center Copayment	$10 per visit	$30 per visit	N/A	$15 per visit	$20 per visit
	Urgent Care Facility Copayment	$50 per visit		N/A	$50 per visit	$50 per visit
	Emergency Room Copayment	$50 per visit			$100 per visit	$100 per visit
	Standard Deductible	N/A		$150 per Member, per year; $450 per family, per year	$500 per Member per year; $1,500 per family per year	$1,000 per Member per year; $3,000 per family per year
	Standard Coinsurance	N/A	20%		N/A	N/A
	Coinsurance Maximum	N/A	$600 per Member, per year; $1,800 per family, per year	$900 per Member, per year; $2,700 per family, per year	N/A	N/A
	Durable Medical Equipment	You pay $0	You pay 20%		You pay 20% after separate $100 per Member, per year deductible	You pay 20% after separate $100 per Member, per year deductible
	Out-of-Pocket Limit	$3,000 per Member, per year; $6,000 per family, per year (4)		N/A	$3,000 per Member, per year; $6,000 per family, per year (4)	$5,000 per Member, per year; $10,000 per family, per year (4)
Inpatient	Inpatient Services; medical, surgical and maternity admissions	You pay $0	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances	Standard Deductible	Standard Deductible
Preventive Care	Immunizations, cancer screenings: mammograms, pap smears, routine colonoscopy; routine physical exams, nutrition counseling, routine hearing exams (one exam each year)	You pay $0		Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0
	Routine Eye Exams (one exam per calendar year 18 years and younger; once every two years thereafter)	You pay $0 (3)		Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0
Eyewear	Frames/Lenses	$40 reimbursement per Member, every two calendar years (3)			$40 reimbursement per Member, per year	N/A
Outpatient	Medical exams, telemedicine and online visits, consultations, medical treatments	Visit Copayment or Specialty Visit Copayment		Standard Deductible and Coinsurance, plus any balances	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment
	Injections (except allergy injections)	You pay $0		Standard Deductible and Coinsurance, plus any balances	You pay $0	Visit Copayment or Specialty Visit Copayment
	Allergy injections	You pay $0		Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0
	Surgery and anesthesia	You pay $0		Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0 at Site of Service providers. Otherwise, Standard Deductible.
	Laboratory tests (including allergy testing)	You pay $0		Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0 at Site of Service providers. Otherwise, Standard Deductible.
	X-ray tests (including ultrasound)	You pay $0		Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0 at Site of Service providers. Otherwise, Standard Deductible.
	MRA, MRI, PET, SPECT, CT Scan, and CTA	You pay $0	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances	Standard Deductible	You pay $0 at Site of Service providers. Otherwise, Standard Deductible.
	Chemotherapy, medical supplies, and drugs	You pay $0	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances	Standard Deductible	Standard Deductible
	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" or "Outpatient Facility 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" or "Outpatient Facility 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" or "Outpatient Facility Care."

HealthTrust		BlueChoice POS Plan (BC3T10)			Access Blue (AB15IPDED)	Access Blue Site of Service (ABSOS20/40/1KDED)
		When Your PCP provides or refers Your care	When You seek care directly from a BlueChoice provider	When You seek care from any out-of-network provider (1)	Network Benefits (2)	Network Benefits (2)
Emergency Room and Urgent Care	Use of the emergency room (copayment waived if you are admitted)	Emergency Room Copayment			Emergency Room Copayment	Emergency Room Copayment
	Use of an urgent care facility	Urgent Care Facility Copayment		Standard Deductible and Coinsurance, plus any balances	Urgent Care Facility Copayment	Urgent Care Facility Copayment
	Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs while in the emergency room	You pay $0		Standard Deductible and Coinsurance, plus any balances	Standard Deductible	Standard Deductible
	Laboratory and x-ray tests while in the emergency room	You pay $0		Standard Deductible and Coinsurance, plus any balances	You pay $0	Standard Deductible
	Ambulance Services - must be medically necessary	You pay $0			Standard Deductible	Standard Deductible
Outpatient Physical Rehab	Physical, Occupational and Speech Therapy	You pay $0, Unlimited visits (3)	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances	Visit Copayment or Specialty Visit Copayment, up to a combined maximum of 60 visits per Member, per year	Visit Copayment, up to a combined maximum of 60 visits per Member, per year
	Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment		Standard Deductible and Coinsurance, plus any balances	Visit Copayment or Specialty Visit Copayment	Visit Copayment
	Chiropractic Care	Visit Copayment or Specialty Visit Copayment, Unlimited visits	N/A	Standard Deductible and Coinsurance, plus any balances	Visit Copayment or Specialty Visit Copayment, up to 12 visits per Member, per year	Visit Copayment, Unlimited Visits
	X-ray tests performed by a chiropractor	You pay $0	N/A	Standard Deductible and Coinsurance, plus any balances	You pay $0	Standard Deductible
	Acupuncture	N/A			N/A	Visit Copayment, up to 12 visit per Member, per year
Behavioral Health Care	Outpatient Behavioral Healthcare and Substance Abuse Treatment	Visit Copayment or Specialty Visit Copayment, Unlimited visits	N/A	Standard Deductible and Coinsurance, plus any balances	Visit Copayment or Specialty Visit Copayment, Unlimited visits	Visit Copayment or Specialty Visit Copayment, Unlimited visits
	Inpatient Behavioral Healthcare and Substance Abuse Treatment	You pay $0	N/A	Standard Deductible and Coinsurance, plus any balances	Standard Deductible	Standard Deductible
Prescription Drugs	Prescription Drugs	Retail Pharmacy: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Maintenance Choice: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 90-day supply through CVS Caremark's Mail Service Pharmacy or at a CVS Pharmacy.			Retail Pharmacy: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Maintenance Choice: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 90-day supply through CVS Caremark's Mail Service Pharmacy or at a CVS Pharmacy.	Retail Pharmacy: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Maintenance Choice: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 90-day supply through CVS Caremark's Mail Service Pharmacy or at a CVS Pharmacy.

$20 Co-Pay

(1) Benefits are limited to the Maximum Allowable Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Self-referred care may require preauthorization/precertification from Anthem.

(2) Referrals are not required for care provided within the Access Blue New England Network.

(3) PCP Referral is not necessary.

(4) The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments You pay during a year for medical and prescription expenses under this medical plan and Your HealthTrust prescription benefit program. It does not include your premium, amounts over the Maximum Allowed Amount, penalties, or charges for noncovered services. Once the combined 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 chart any reference to year means plan year. Plan year is July 1 through June 30.

This chart is intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.