HealthTrust

Anthem BlueCross BlueShield

Access Blue New England SM
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.	$15 per visit
Walk-In Center Copayment Applies each time You visit a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$15 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's urgent care facility for diagnosis, care and treatment of illness or injury.	$50 per visit
Emergency Room Copayment	$100 per visit
Standard Deductible	$500 per Member, per year $1,500 per family, per year
Standard Coinsurance	N/A
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit	$3,000 per Member, per year $6,000 per family, per year
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 schedule any reference to year means plan year unless otherwise noted. Plan year is July 1 through June 30.

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	
In a Physical Rehabilitation Facility (Facility charges)	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) Skilled Nursing Facility admissions are limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law or permitted by the Plan 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 -Diabetes management program -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.	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, telemedicine and online visits, consultations, medical treatments and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (except allergy injections)	You pay $0
Allergy injections	
Office surgery (including anesthesia)	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan and CTA	Standard Deductible
Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about 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, telemedicine and online visits	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 Physician and professional services for 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	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 Medically Necessary Emergency Transport	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 • **Office visits** - up to 12 visits per Member, per year	
• **X-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia, telemedicine and online visits	Visit Copayment or Specialty Visit Copayment
Home Health Agency services	Standard Deductible
Hospice	You pay $0
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/Telemedicine/Online 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	You pay $0
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • 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.	