HealthTrust

Anthem

Access Blue New England SM
Site of Service Plan
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 Network Primary Care Provider (PCP) or Network obstetrician/gynecologist (OB/GYN).	$20 per visit
Specialty Visit Copayment Applies each time You visit a Network specialist.	$40 per visit
Walk-In Center Copayment	$20 per visit
Urgent Care Facility Copayment	$50 per visit
Emergency Room Copayment	$100 per visit
Standard Deductible	$1,000 per Member, per year $3,000 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	$5,000 per Member, per year $10,000 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 plan. 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 Cost Sharing Schedule any reference to year means Plan Year unless otherwise noted. Plan Year is January 1 through December 31.

Coverage Outline	YOUR COST
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 provider and professional services (Such as provider 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: -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as mammograms, pap smears, prostate-specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -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 Provider's Office, Walk-In Center or Retail Health Clinic, or furnished by a Site of Service Provider (such as an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider)	
Medical exams, telemedicine and online visits, consultations, and medical treatments	Visit Copayment or Specialty Visit Copayment**
Injections (except allergy injections)	
Allergy injections	You pay $0**
Office surgery (including anesthesia)	Visit Copayment or Specialty Visit Copayment**
Surgery and anesthesia	You pay $0 at Site of Service providers. Otherwise, Standard Deductible**
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan and CTA	
Medical supplies (including hearing aids), chemotherapy, infusion therapy, and drugs	Standard Deductible**
Provider services at a Walk-In Center or Retail Health Clinic	Walk-In Center Copayment
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).

** For non-emergency services furnished by an out-of-network provider within an in-network facility, Your cost will be the in-network cost, unless you are provided notice and give your consent. Please refer to Your Subscriber Certificate for details.

	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 provider, telemedicine and online visits	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	Standard Deductible**
Provider and professional services for the delivery of a baby Provider 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 (including hearing aids), drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
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 an Urgent Care Facility	Urgent Care Facility Copayment
Provider(s) fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible††#
Laboratory and x-ray tests	
Ambulance Services	
Medically Necessary ambulance 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**
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** Unlimited Medically Necessary visits	
• **X-ray tests** furnished by a chiropractor	Standard Deductible
Acupuncture – Unlimited Medically Necessary visits by a provider or licensed acupuncturist	Visit Copayment
Early Intervention Services	You pay $0
IV. Home Care	
Provider services Medical exams, injections, medical treatments, surgery and anesthesia, telemedicine and online visits	Visit Copayment or Specialty 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

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†† For out-of-network emergency services, Your cost will be the in-network cost, except for some post stabilization services for which you are provided notice and give consent. Please refer to Your Subscriber Certificate for details.

Visit Copayment, not Standard Deductible, applies for provider(s) fee for mental health and substance use care.

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Use Care)	
Office Visits/Telemedicine/Online Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Use Care Visits:** Unlimited Medically Necessary visits (including detoxification and substance use rehabilitation services) **Applied Behavioral Analysis:** Unlimited Medically Necessary visits for treatment of pervasive developmental disorder or autism.	Visit Copayment or Specialty Visit Copayment**
Partial Hospitalization and Outpatient Treatment	
Mental Disorders: Unlimited Medically Necessary care **Substance Use Disorders:** Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0**
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Use Disorders:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance Use Disorder rehabilitation - Unlimited Medically Necessary Inpatient days	Standard Deductible**
VI. Prescription Eyewear	
N/A	

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