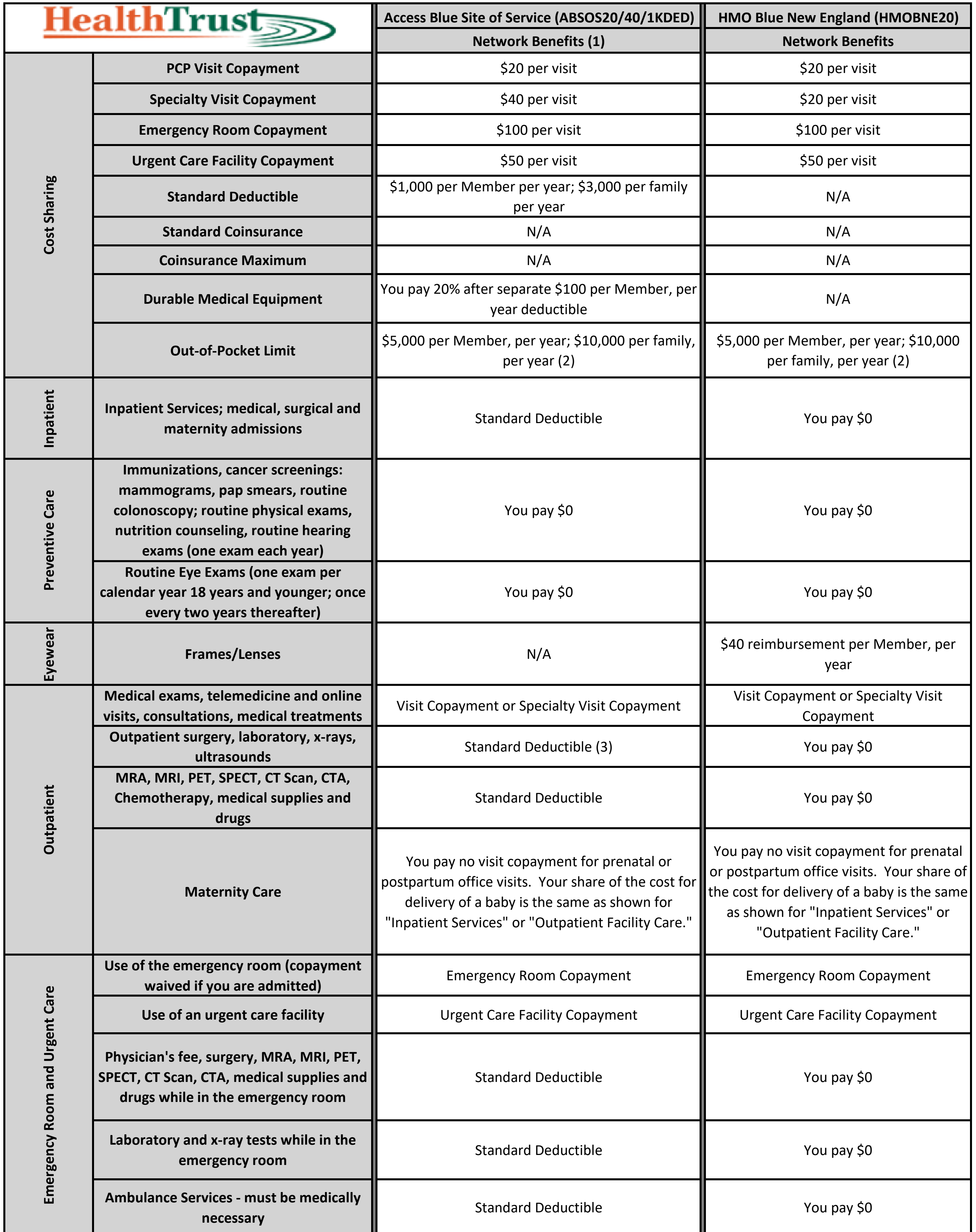
SAU #55 - HASS and HEA - 2017-2018



HealthTrust		Access Blue Site of Service (ABSOS20/40/1KDED)	HMO Blue New England (HMOBNE20)
		Network Benefits (1)	Network Benefits
Cost Sharing	PCP Visit Copayment	$20 per visit	$20 per visit
	Specialty Visit Copayment	$40 per visit	$20 per visit
	Emergency Room Copayment	$100 per visit	$100 per visit
	Urgent Care Facility Copayment	$50 per visit	$50 per visit
	Standard Deductible	$1,000 per Member per year; $3,000 per family per year	N/A
	Standard Coinsurance	N/A	N/A
	Coinsurance Maximum	N/A	N/A
	Durable Medical Equipment	You pay 20% after separate $100 per Member, per year deductible	N/A
	Out-of-Pocket Limit	$5,000 per Member, per year; $10,000 per family, per year (2)	$5,000 per Member, per year; $10,000 per family, per year (2)
Inpatient	Inpatient Services; medical, surgical and maternity admissions	Standard Deductible	You pay $0
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	You pay $0
	Routine Eye Exams (one exam per calendar year 18 years and younger; once every two years thereafter)	You pay $0	You pay $0
Eyewear	Frames/Lenses	N/A	$40 reimbursement per Member, per year
Outpatient	Medical exams, telemedicine and online visits, consultations, medical treatments	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment
	Outpatient surgery, laboratory, x-rays, ultrasounds	Standard Deductible (3)	You pay $0
	MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	Standard Deductible	You pay $0
	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."
Emergency Room and Urgent Care	Use of the emergency room (copayment waived if you are admitted)	Emergency Room Copayment	Emergency Room Copayment
	Use of an urgent care facility	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	Standard Deductible	You pay $0
	Laboratory and x-ray tests while in the emergency room	Standard Deductible	You pay $0
	Ambulance Services - must be medically necessary	Standard Deductible	You pay $0

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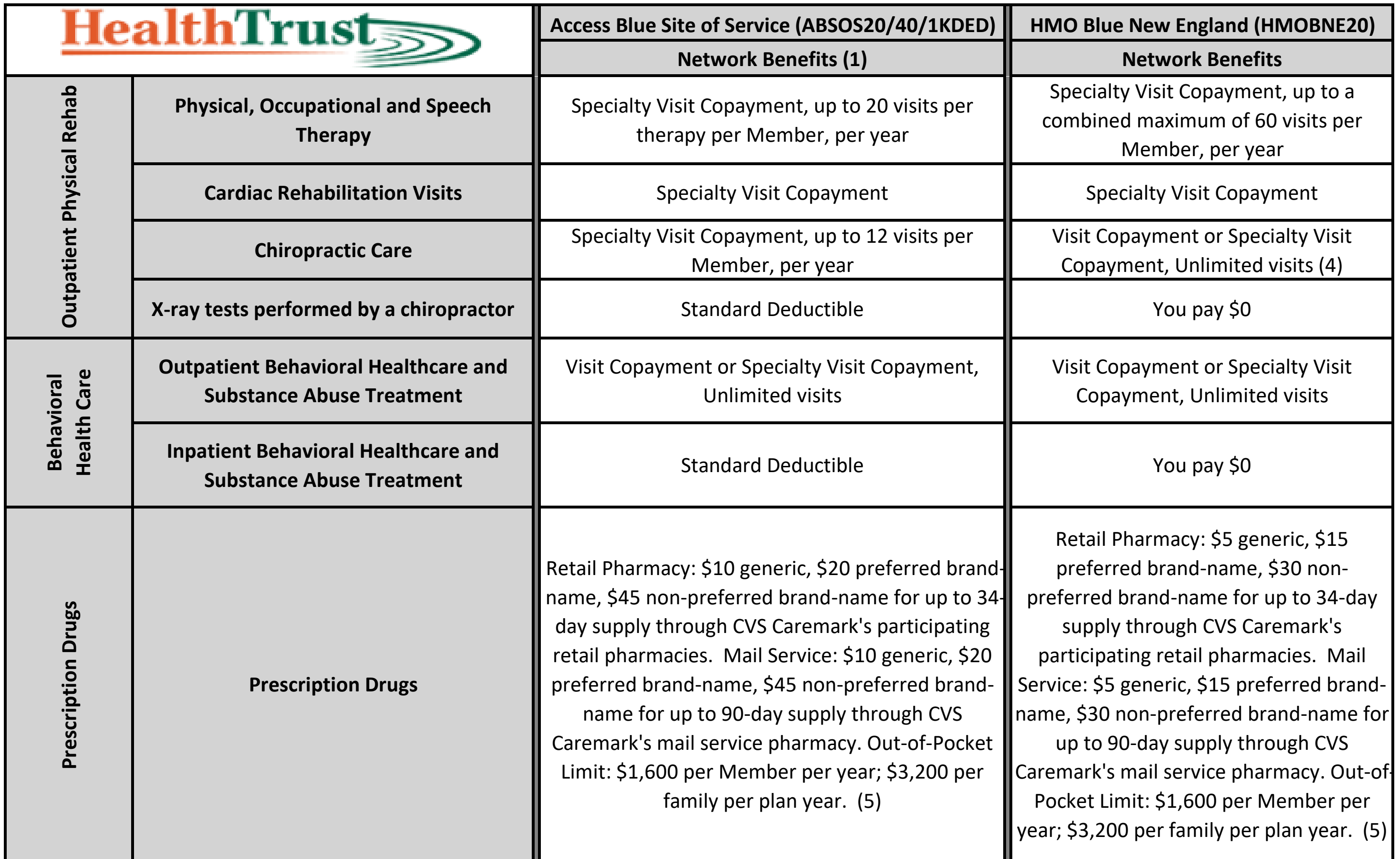

HealthTrust		Access Blue Site of Service (ABSOS20/40/1KDED)	HMO Blue New England (HMOBNE20)
		Network Benefits (1)	**Network Benefits**
Outpatient Physical Rehab	**Physical, Occupational and Speech Therapy**	Specialty Visit Copayment, up to 20 visits per therapy per Member, per year	Specialty Visit Copayment, up to a combined maximum of 60 visits per Member, per year
	Cardiac Rehabilitation Visits	Specialty Visit Copayment	Specialty Visit Copayment
	Chiropractic Care	Specialty Visit Copayment, up to 12 visits per Member, per year	Visit Copayment or Specialty Visit Copayment, Unlimited visits (4)
	X-ray tests performed by a chiropractor	Standard Deductible	You pay $0
Behavioral Health Care	**Outpatient Behavioral Healthcare and Substance Abuse Treatment**	Visit Copayment or Specialty Visit Copayment, Unlimited visits	Visit Copayment or Specialty Visit Copayment, Unlimited visits
	Inpatient Behavioral Healthcare and Substance Abuse Treatment	Standard Deductible	You pay $0
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. Mail Service: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 90-day supply through CVS Caremark's mail service pharmacy. Out-of-Pocket Limit: $1,600 per Member per year; $3,200 per family per plan year. (5)	Retail Pharmacy: $5 generic, $15 preferred brand-name, $30 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Mail Service: $5 generic, $15 preferred brand-name, $30 non-preferred brand-name for up to 90-day supply through CVS Caremark's mail service pharmacy. Out-of-Pocket Limit: $1,600 per Member per year; $3,200 per family per plan year. (5)

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

(2) Includes all Deductibles, Coinsurance, and Copayments you pay during a year. It does not include Your premium, penalties, amounts over the Maximum Allowable Amount (MAA) or charges for noncovered services. 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.

(3) Laboratory tests will cost $0 if performed at a preferred site of service; Outpatient surgery will cost $75 if performed at a preferred site of service.

(4) PCP Referral is not necessary.

(5) Out-of-Pocket Limit Applies Per Plan Year (January Plans: 1/1 through 12/31; July Plans: 7/1 through 6/30).

Please note that throughout this chart any reference to year means calendar year. Beginning 7/1/17, any reference to year will change from calendar year to plan year (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.