



Access Blue New EnglandSM 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 |
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| Visit Copayment Applies each time You visit Your Network Primary Care Provider (PCP) or Network obstetrician/gynecologist (OB/GYN). | \$15 per visit |
| Specialty Visit Copayment Applies each time You visit a Network specialist. | \$15 per visit |
| Walk-In Center Copayment | \$15 per visit |
| Urgent Care Facility Copayment | \$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 | \$100 per Member, per year |
| Coinsurance | 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 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 July 1 through June 30.

Coverage Outline

YOUR COST

| I. Inpatient Services | |
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| 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: -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 Physician's Office, Walk-In Center or Retail Health Clinic, 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, and medical treatments | 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** |
| 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 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 | Standard Deductible** |
| 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 (including hearing aids), drugs, other ancillaries, observation | |
| 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 an 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 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 | Specialty Visit Copayment** |
| Cardiac Rehabilitation Visits | |
| Chiropractic Care | |
| • Office visits - up to 12 visits per Member, per year | You pay \$0 |
| • X-ray tests furnished by a chiropractor | |
| Early Intervention Services | You pay \$0 |
| 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 |

†† 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.

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| YOUR COST | |
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| V. Behavioral Health Care (Mental Health and Substance Use Care) | |
| Outpatient/Office/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 Intensive Outpatient Treatment Programs | |
| 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: <ul style="list-style-type: none"> • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance Use Disorder rehabilitation - Unlimited Medically Necessary Inpatient days | 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. | |

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