HealthTrust Plan Comparison

HealthTrust		BlueChoice POS Plan (BC2T20)		Access Blue (AB5)	Access Blue (AB20)
		PCP Referred Benefits	*Self-Referred Benefits (5)*	*Network Benefits (7)*	*Network Benefits (7)*
Cost Sharing	PCP Visit Copayment	$20 per visit	N/A	$5 per visit	$20 per visit
	Specialty Visit Copayment	$20 per visit	N/A	$5 per visit	$20 per visit
	Emergency Room Copayment	$100 per visit		$25 per visit	$100 per visit
	Urgent Care Facility Copayment	$50 per visit	N/A	$25 per visit	$50 per visit
	Standard Deductible	N/A	$250 per Member, per year; $500 per family, per year	N/A	N/A
	Standard Coinsurance	N/A	20%	N/A	N/A
	Coinsurance Maximum	N/A	$900 per Member, per year; $1,800 per family, per year	N/A	N/A
	Durable Medical Equipment	You pay 20% after separate $100 per Member, per year deductible		You pay 20%	You pay 20%
	Out-of-Pocket Limit (2)	$5,000 per Member, per year; $10,000 per family, per year	N/A	$5,000 per Member, per year; $10,000 per family, per year	$5,000 per Member, per year; $10,000 per family, per year
Inpatient	Inpatient Services; medical, surgical and maternity admissions	You pay $0	Standard Deductible and Coinsurance, plus any balances	You pay $0	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	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 (1)	Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0
Eyewear	Frames/Lenses	N/A		$40 reimbursement per Member, per year	$40 reimbursement per Member, per year
Outpatient	Medical exams, 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
	Outpatient surgery, laboratory, x-rays, ultrasounds	You pay $0	Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0
	MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	You pay $0	Standard Deductible and Coinsurance, plus any balances	You pay $0	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."	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	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	You pay $0	You pay $0
	Laboratory and x-ray tests while in the emergency room	You pay $0	Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0
	Ambulance Services - must be medically necessary	You pay $0		You pay $0	You pay $0

HealthTrust Plan Comparison

HealthTrust		BlueChoice POS Plan (BC2T20)		Access Blue (AB5)	Access Blue (AB20)
		PCP Referred Benefits	*Self-Referred Benefits (5)*	*Network Benefits (7)*	*Network Benefits (7)*
Outpatient Physical Rehab	Physical, Occupational and Speech Therapy	You pay $0, up to a combined maximum of 60 visits per Member, per year (4)	Standard Deductible and Coinsurance, plus any balances	Specialty Visit Copayment, up to a combined maximum of 60 visits per Member, per year	Specialty 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	Specialty Visit Copayment	Specialty Visit Copayment
	Chiropractic Care	You pay $0, up to 35 visits per Member, per year (1)(6)	Standard Deductible and Coinsurance, plus any balances	Specialty Visit Copayment, up to 12 visits per Member, per year	Specialty Visit Copayment, up to 12 visits per Member, per year
	X-ray tests performed by a chiropractor	You pay $0	Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0
Behavioral Health Care	Outpatient Behavioral Healthcare and Substance Abuse Treatment	Visit Copayment or Specialty Visit Copayment (1), Unlimited visits	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 (1)	Standard Deductible and Coinsurance, plus any balances	You pay $0	You pay $0
Prescription Drugs	Prescription Drugs	Retail Pharmacy: $10 generic, $25 preferred brand-name, $40 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Mail Service: $10 generic, $40 preferred brand-name, $70 non-preferred brand-name for up to 90-day supply through CVS Caremark's mail service pharmacy. **Out-of-Pocket Limit (3):** $1,600 per Member per year; $3,200 per family per plan year.		Retail Pharmacy: $3 generic, $15 brand name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Mail Service: $1 generic or brand name for up to 90-day supply through CVS Caremark's mail service pharmacy. **Out-of-Pocket Limit (3)**: $1,600 per Member per year; $3,200 per family per plan year.	Retail Pharmacy: $10 generic, $25 preferred brand-name, $40 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Mail Service: $10 generic, $40 preferred brand-name, $70 non-preferred brand-name for up to 90-day supply through CVS Caremark's mail service pharmacy. **Out-of-Pocket Limit (3):** $1,600 per Member per year; $3,200 per family per plan year.

(1) PCP Referral is not necessary.

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

(4) Unlimited visits effective 7/1/16.

(5) 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.

(6) Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

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

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.