

YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits	Visit Copayment or Specialty Visit Copayment
Substance Abuse Visits: Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care	You pay \$0
Substance Abuse Conditions: Unlimited Medically Necessary care for rehabilitation and detoxification	
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days	You pay \$0
Substance Abuse Conditions:	
<ul style="list-style-type: none"> • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days 	
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.	



**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
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	\$20 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	\$20 per visit
Emergency Room Copayment	\$100 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	\$50 per visit
Standard Deductible	
Standard Coinsurance	N/A
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics	
Deductible	N/A
Coinsurance	20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	\$5,000 per Member, per year \$10,000 per family, per year

*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.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline

		YOUR COST
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay \$0	
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year		
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year		
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law 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 -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, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	
Injections (including allergy injections)	You pay \$0	
Office surgery (including anesthesia)		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits)	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).	
Please see Your Subscriber Certificate for information about maternity care.		

		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	Visit Copayment or Specialty Visit Copayment	
Services of a surgeon, operating room for surgery and anesthesia	You pay \$0	
Physician and professional services for the delivery of a baby or 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		
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 a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment	
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay \$0	
Laboratory and x-ray tests		
Ambulance Services Medically Necessary Emergency Transport		
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 • Laboratory and 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	Visit Copayment or Specialty Visit Copayment	
Home Health Agency services	You pay \$0	
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Coinsurance	