



**School Administrative Unit #02
Ashland**

|  | | Access Blue (AB20) | Access Blue Site of Service (ABSOS20/40/1KDED) |
|--|--|---|---|
| | | RX Benefit: R10/25/40M10/40/70/3K | RX Benefit: R10/25/40M10/40/70/5K |
| | | Network Benefits (1) | Network Benefits (1) |
| Cost Sharing | Visit Copayment | \$20 per visit | \$20 per visit |
| | Specialty Visit Copayment | \$20 per visit | \$40 per visit |
| | Walk-In Center or Retail Clinic Copayment | \$20 per visit | \$20 per visit |
| | Urgent Care Facility Copayment | \$50 per visit | \$50 per visit |
| | Emergency Room Copayment | \$100 per visit | \$100 per visit |
| | Standard Deductible | N/A | \$1,000 per Member per year; \$3,000 per family per year |
| | Standard Coinsurance | N/A | N/A |
| | Coinsurance Maximum | N/A | N/A |
| | Durable Medical Equipment | You pay 20% | You pay 20% after separate \$100 per Member, per year deductible |
| Out-of-Pocket Limit | \$3,000 per Member, per year; \$6,000 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 | You pay \$0 | Standard Deductible |
| Preventive Care | Immunizations, cancer screenings: mammograms, pap smears, routine colonoscopy; routine physical exams, nutrition counseling, diabetes management program, routine hearing exams (one exam each year) | You pay \$0 | You pay \$0 |
| | Routine Eye Exams (one exam per year 18 years and younger; once every two years thereafter) | You pay \$0 | You pay \$0 |
| Eyewear | Frames/Lenses | \$40 reimbursement per Member, per year | N/A |
| Outpatient | Medical exams, telemedicine and online visits, consultations, medical treatments | Visit Copayment or Specialty Visit Copayment | Visit Copayment or Specialty Visit Copayment |
| | Injections (except allergy injections) | You pay \$0 | Visit Copayment or Specialty Visit Copayment |
| | Allergy Injections | You pay \$0 | You pay \$0 |
| | Surgery and anesthesia | You pay \$0 | You pay \$0 at Site of Service providers. Otherwise, Standard Deductible. |
| | Laboratory tests (including allergy testing) | You pay \$0 | You pay \$0 at Site of Service providers. Otherwise, Standard Deductible. |
| | X-ray tests (including ultrasound) | You pay \$0 | You pay \$0 at Site of Service providers. Otherwise, Standard Deductible. |
| | MRA, MRI, PET, SPECT, CT Scan, and CTA | You pay \$0 | You pay \$0 at Site of Service providers. Otherwise, Standard Deductible. |
| | Medical Supplies, Chemotherapy, Infusion Therapy, and Drugs | You pay \$0 | Standard Deductible |
| | 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." |

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| | | Network Benefits (1) | Network Benefits (1) |
| 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 | You pay \$0 | Standard Deductible |
| | Laboratory and x-ray tests | You pay \$0 | Standard Deductible |
| | Ambulance Services - must be medically necessary | You pay \$0 | Standard Deductible |
| Outpatient Physical Rehab | Physical, Occupational and Speech Therapy | Specialty Visit Copayment, up to a combined maximum of 60 visits per Member, per year | Visit Copayment, up to a combined maximum of 60 visits per Member, per year |
| | Cardiac Rehabilitation Visits | Specialty Visit Copayment | Visit Copayment |
| | Chiropractic Care | Specialty Visit Copayment, Unlimited visits | Visit Copayment, Unlimited Visits |
| | X-ray tests performed by a chiropractor | You pay \$0 | Standard Deductible |
| | Acupuncture | Specialty Visit Copayment, Unlimited visits | Visit Copayment, Unlimited visits |
| Home Care | Physician Services (medical exams, injections, medical treatments, surgery and anesthesia, telemedicine and online visits) | Visit Copayment or Specialty Visit Copayment | Visit Copayment or Specialty Visit Copayment |
| | Home Health Agency Services | You pay \$0 | Standard Deductible |
| | Hospice | You pay \$0 | You pay \$0 |
| Behavioral Health Care | Outpatient Behavioral Healthcare (Mental Health, Substance Use Care, and Applied Behavioral Analysis) | Visit Copayment or Specialty Visit Copayment, Unlimited visits | Visit Copayment or Specialty Visit Copayment, Unlimited visits |
| | Inpatient Behavioral Healthcare (Mental Health and Substance Use Care) | You pay \$0 | Standard Deductible |
| 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. Maintenance Choice: \$10 generic, \$40 preferred brand-name, \$70 non-preferred brand-name for up to 90-day supply through CVS Caremark's Mail Service Pharmacy or at a CVS Pharmacy. | 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. Maintenance Choice: \$10 generic, \$40 preferred brand-name, \$70 non-preferred brand-name for up to 90-day supply through CVS Caremark's Mail Service Pharmacy or at a CVS Pharmacy. |
| Resource Links | | Medical Benefit Cost Sharing Prescription Benefit Summary | Medical Benefit Cost Sharing Site of Service Info Prescription Benefit Summary |

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

(2) 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 program. 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 chart any reference to year means plan year. Plan year is 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.