FY22-23 Somerset Health Plan Group Benefit Comparison
Blue Cross Blue Shield of Massachusetts

Effective 7/1/2022-6/30/2023	Blue Cross Blue Shield		
BENEFIT	Network Blue New England $250 Deductible	Blue Care Elect $250 Ded **In-Network**	Blue Care Elect $250 Ded **Out-of-Network**
	Your Responsibility	Your Responsibility	Your Responsibility
Deductible	**$250 Per Member Per Plan Year** **$750 Per Family Per Plan Year**	**$250 Per Member Per Plan Year** **$750 Per Family Per Plan Year** **In and Out of Network Combined** *Deductible does not apply to In-Network preventive heatlh services, prescription drug benefits and certain other services as noted.	
Plan Year Out of Pocket Maximum	**$5,000 Per Member Per Plan Year** **$10,000 Per Family Per Plan Year** *Calculation includes deductible and copayments for medical and Prescription Drugs	**$5,000 Per Member Per Plan Year** **$10,000 Per Family Per Plan Year** **In and Out of Network Combined** *Calculation Includes Deductible, Copayments and Coinsurance for Medical and Prescriiption Drug Benefits	
Lifetime Benefit Maxiumum	None	None	None
Eligible Dependents	***Dependents are covered until the end of the calendar month in which they turn 26, regardless of the dependent's financial dependency, student status or emplyment status.***		
Waiting Periods/Pre-Existing Condition Exclusion	None	None	None
INPATIENT			
General Hospital, Mental Hospital, Substance Abuse Facility and Skilled Nursing Facility (Semi-Private Room and Board and Special Services)	$100 Copayment Per Admission After Deductible (Copayments limited to $400 per calendar year)	$200 Copayment per Admission after Deductible ($800 Per member per calendar year for all inpatient admissions	20% Coinsurance after Deductible (and amount above allowed Charge)
OUTPATIENT HOSPITAL			
Emergency Room Visits for Emergency of Accident Care	$100 Copayment Per Visit, No Deductible. *waived if admitted.	$100 Copayment For Emergency Room Services *waived if admitted.	$100 Copayment For Emergency Room Services *waived if admitted.
Hospital Outpatient Medical Services	$20 Copayment per Visit	$30 Copayment per Visit	20% Coinsurance After Deductible (and amount above allowed charge)
Outpatient Surgery	$50 Copayment Per Admission After Deductible	$100 Copayment Per Admission After Deductible	20% Coinsurance After Deductible (and amount above allowed charge)
Removal of teeth Impacted in Bone	Covered Same as Other Surgical Services	Not Covered, member pays all charges	Not Covered member pays all charges
Radiation and Chemotherapy	No Cost After Deductible	No Cost After Deductible	20% Coinsurance After Deductible (and amount above allowed charge)
High Tech Radiology (MRI, CT, PT Scans)	$100 Copayment for Hospitals $50 for Other Providers	$100 Copayment per category of test per date of service After Deductible	20% Coinsurance After Deductible (and amount above allowed charge)
Physical Therapy	$10 Copayment Per Visit	$30 Copayment per Visit	20% Coinsurance After Deductible (and amount above allowed charge)

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PHYSICIAN'S OFFICE			
PCP and/or Specialist OV	$10 Copayment per Visit	$15 Copayment per Visit	20% Coinsurance After Deductible (and amount above allowed charge)
Urgent Care Centers	$20 Copayment per Visit	$30 Copayment per Visit	20% Coinsurance After
Surgery	$10 Per Visit with PCP, OB/GYN, NP, PA or Nurse Midwife $20 Per Visit Other Covered Providers	$15 Copayment per Visit	20% Coinsurance After Deductible (and amount above allowed charge)
Medical Care, Mental Health Care, Substance Abuse Care	$10 Copayment per Visit	$15 Copayment per Visit	20% Coinsurance After Deductible (and amount above allowed charge)
Well Child Care	No Charge. No Benefit Limit	No Copay based on the following schedule: 10 Visits 1st Year 3 Visits 2nd Year 2 Visits at Age 2 1 Visit/Cal Yr 3-18	20% Coinsurance After Deductible based on following schedule: 10 Visits 1st Year 3 Visits 2nd Year 2 Visits at Age 2 1 Visit/Cal Yr 3-18
Routine Vision Exam - Preventative Physicals $0 Copay	1 Exam Per Member every 24 months	1 Exam Per Member every 24 months	20% Coinsurance After Deductible (and amount above allowed charge)
Adult Routine Physicals - Preventative Physicals $0 Copay	GYN Exam limited to 1 Exam Per Calendar Year	1 Exam Per Member Per Calendar Year	20% Coinsurance After Deductible (and amount above allowed charge)
Family Planning Services	No Cost	No Cost	20% Coinsurance After Deductible (and amount above allowed charge)
OTHER OUTPATIENT			
Home Health Care and Hospice Services	No Cost After Deductible	No cost After Deductible	20% Coinsurance After Deductible (and amount above allowed charge)
Durable Medical Equipment and Prosthetic Devices	No Cost	No Cost	20% Coinsurance After Deductible (and amount above allowed charge)
Ambulance	No Cost After Deductible	No Cost After Deductible	No Cost After Deductible
Chiropractor Visits	$10 Copayment per Visit	$30 Copayment per Visit	20% Coinsurance after Deductible (and amount above allowed Charge)
Acupuncture Visits	$20 Copayment per Visit (up to 12 visits per calendar year)	$30 Copayment per Visit (up to 12 visits per calendar year)	20% Coinsurance After Deductible (and amount above allowed charge)

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Prescription Drugs ***Now offering Smart90: Members pay the same amount for a 90-day supply at a CVS Retail Pharmacy as they do through Express Scripts (ESI Mail service pharmacy)**	30 Day Supply Retail Pharmacy or 90 Day Supply Mail Service Pharmacy: Tier 1: $10 Copay Tier 2: $25 Copay Tier 3: $35 Copay No Deductible Non Formulary Drugs: All Charges	30 Day Supply Retail Pharmacy or 90 Day Supply Mail Service Pharmacy: Tier 1: $10 Copay Tier 2: $25 Copay Tier 3: $50 Copay No Deductible Non Formulary Drugs: All Charges	Not Covered member pays all charges
OTHER BENEFITS			
Fitness Benefit/Special Programs (See Plan for Details)	Up to $150 Reimbursement toward participation in qualified fitness programs or equipment Enroll in a Qualified Weight Watchers or Hospital Based Weight Loss Program and REceive up to $150 Per Calendar Year toward your program fees. Discounts on Eyewear, Acupuncture, Massage Therapy, Nutrition Counseling, Personal Health Assessment, Lifestart Prenatal Care Programs.	Up to $150 Reimbursement toward participation in qualified fitness programs or equipment Enroll in a Qualified Weight Watchers or Hospital Based Weight Loss Program and REceive up to $150 Per Calendar Year toward your program fees. Discounts on Eyewear, Acupuncture, Massage Therapy, Nutrition Counseling, Personal Health Assessment, Lifestart Prenatal Care Programs.	

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.