Medical and Prescription Drug Coverage: All Plans

Beth Israel Lahey Health

	BILH Network High Deductible HSA		BILH Network Premier HMO		Flex HMO			Access PPO	
	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2	Tier 3	In-Network	Out-of-Network
Annual Deductible	$2,000 member/ $4,000 family (includes prescription drug costs)	$4,000 member/ $8,000 family (includes prescription drug costs)	$800 member/ $1,600 family	$2,500 member/ $5,000 family	$800 member/ $1,600 family	$2,500 member/ $5,000 family	$6,000 member/ $12,000 family	$500 member/ $1,000 family	$2,000 member/ $4,000 family
BILH Maximum Annual HSA Contribution *(on a per-pay period basis)*	$1,000 member/$2,000 family		Not Applicable		Not Applicable			Not Applicable	
Out-of-Pocket Maximum* (Includes medical copays, coinsurance and deductibles)	$5,000 member/ $10,000 family (includes prescription drug costs)	$7,500 member/ $15,000 family (includes prescription drug costs)	$2,750 member/$5,500 family		$7,500 member/$15,000 family			$6,000 member/$12,000 family	
Preventive Care Visits	$0 (covered in full)		$0 (covered in full)		$0 (covered in full)			$0 (covered in full)	30% coinsurance after deductible
PCP Office Visits	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	$0 (covered in full)	$50 copay (covered in full for children ages 18 and under)	$0 (covered in full)	$50 copay (covered in full for children ages 18 and under)	$80 copay ($50 copay for children ages 18 and under)	$40 copay	30% coinsurance after deductible
Specialist Office Visits	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	$40 copay	$100 copay ($40 copay for children ages 18 and under)	$40 copay	$100 copay ($40 copay for children ages 18 and under)	$160 copay ($100 copay for children ages 18 and under)	$40 copay	30% coinsurance after deductible
Outpatient Mental Health/ Substance Use Disorder Treatment	20% coinsurance after deductible		$0 (covered in full)		$0 (covered in full)			$0 (covered in full)	30% coinsurance after deductible
Inpatient Mental Health/ Substance Use Disorder Treatment	20% coinsurance after deductible		10% coinsurance after deductible		10% coinsurance after deductible			10% coinsurance after deductible	30% coinsurance after deductible
Urgent Care	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	$40 copay	$100 copay ($40 copay for children ages 18 and under)	$40 copay	$100 copay ($40 copay for children ages 18 and under)	$160 copay ($100 copay for children ages 18 and under)	$40 copay	30% coinsurance after deductible
Emergency Room (ER) Care (Waived if admitted)	20% coinsurance after deductible	20% coinsurance after deductible	$200 copay		$200 copay			$150 copay	
Emergency Admission	20% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible		10% coinsurance after deductible			10% coinsurance after deductible	
Inpatient Hospital	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	50% coinsurance after deductible (30% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible
Day Surgery (Including diagnostic scoping procedures)	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	50% coinsurance after deductible (30% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible
Hospital Based Lab/X-Ray/ Diagnostic and High End Radiology (MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	$40 copay	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	$40 copay	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	50% coinsurance after deductible (30% coinsurance after deductible for children ages 18 and under)	$40 copay	30% coinsurance after deductible
Non-Hospital Based Lab/X-Ray/ Diagnostic and High End Radiology (MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	$40 copay	$100 copay ($40 copay for children ages 18 and under)	$40 copay	$100 copay ($40 copay for children ages 18 and under)	$160 copay ($100 copay for children ages 18 and under)	$40 copay	30% coinsurance after deductible

Prescription Drug Coverage		BILH Network High Deductible HSA	BILH Network Premier HMO	Flex HMO	Access PPO
Deductible**		Combined with Medical Deductible: $2,000 member/$4,000 family for BILH Pharmacy & Home Delivery; $4,000 member/$8,000 family for Retail Pharmacy	N/A	N/A	N/A
Preventive Medications		$0 (covered in full)	$0 (covered in full)	$0 (covered in full)	$0 (covered in full)
BILH Pharmacy and Home Delivery – 30 Day Supply	***Generic***	20% coinsurance after deductible	$5	$5	$10
	Preferred		$25	$25	$30
	Non-preferred		$40	$40	$60
	Specialty		$40	$40	$100
BILH Pharmacy and Home Delivery – 90 Day Supply	***Generic***	20% coinsurance after deductible	$12.50	$12.50	$25
	Preferred		$62.50	$62.50	$75
	Non-preferred		$100	$100	$150
	Specialty		$100	$100	$250
Retail Network Pharmacy – 30 Day Supply Only	***Generic***	40% coinsurance after deductible for generic, preferred, and non-preferred Specialty medications not covered	$10	$10	$10
	Preferred		$30	$30	$30
	Non-preferred		$60	$60	$60
	Specialty		Not covered	Not covered	Not covered
Out-of-Pocket Maximum		Combined with Medical Out-of-Pocket Maximum: $5,000 member/$10,000 family for BILH Pharmacy & Home Delivery; $7,500 member/$15,000 family for Retail Pharmacy	Separate Prescription Drug Out-of-Pocket Maximum: $3,000 member/$6,000 family	Separate Prescription Drug Out-of-Pocket Maximum: $3,000 member/$6,000 family	Separate Prescription Drug Out-of-Pocket Maximum: $3,000 member/$6,000 family

** In the BILH Network High Deductible HSA plan, prescription drug costs are combined with the Out-of-Pocket Maximums. In the BILH Network Premier, Flex HMO, and Access PPO plans, prescription drugs have separate Out-of-Pocket Maximums. Therefore, in those plans, prescription drug costs do not count toward meeting the medical Out-of-Pocket Maximums.*

*** Deductible does not apply for generic drugs on the **HDHP Preventive Drug list**.*

Note: Family applies when one or more dependents are enrolled in the plan.