



MASSACHUSETTS

## SUMMARY OF BENEFITS



# Network Blue<sup>®</sup> Select \$500 Deductible

Plan-Year Deductible: \$500/\$1,000

This health plan includes a limited provider network called HMO Blue Select. It provides access to a network that is smaller than the Blue Cross Blue Shield of Massachusetts HMO Blue provider network. **In this plan, members have access to network benefits only from the providers in the HMO Blue Select network.** For help in finding which providers are included in the HMO Blue Select network, check the most current provider directory for your health plan option or visit the online provider search tool at [bluecrossma.com/findadoctor](http://bluecrossma.com/findadoctor) and search for HMO Blue Select.

**Download the MyBlue Member App**—Get instant and secure access to your personal health care information any time you need it. A simple tap connects you to your claims history, your ID card, financial accounts, even your doctor. Download the app from the App Store™ or Google Play™.



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

# Your Care

## Your Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the HMO Blue Select network of providers in Massachusetts. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at [bluecrossma.com](http://bluecrossma.com); consult the Provider Directory; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

## Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist within the HMO Blue Select network, who is likely affiliated with your PCP's hospital or medical group. You will not need prior authorization or referral to see an HMO Blue Select network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

## Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible for medical benefits is **\$500** per member (or **\$1,000** per family). Your deductible for prescription drug benefits is **\$100** per member (or **\$200** per family).

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$2,500** per member (or **\$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** per family).

## Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

## Telehealth Services

You are covered for certain medical and behavioral health services for conditions that can be treated through video visits from an approved Telehealth provider. These Telehealth services are available by using your computer or mobile device when you prefer not to make an in-person visit for any reason to a doctor or therapist. For a list of Telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at [bluecrossma.com](http://bluecrossma.com); consult the Provider Directory; or call the Member Service number on your ID card.

## Service Area

The plan's service area includes all Massachusetts counties except Dukes, Barnstable and Nantucket.

## When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

## Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

# Your Medical Benefits

Covered Services	Your Cost
<b>Preventive Care</b>	
Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
<b>Outpatient Care</b>	
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by:	
• Your PCP, OB/GYN physician, nurse practitioner, nurse midwife, physician assistant, or limited services clinic	\$20 per visit, no deductible
• Other covered providers	\$60 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year)	\$20 per visit, no deductible
Mental health and substance abuse treatment	\$10 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year for each type of therapy*)	\$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office or health center, when performed by:	
• Your PCP, OB/GYN physician, nurse practitioner, nurse midwife, or physician assistant	\$20 per visit***, no deductible
• Other covered providers	\$60 per visit***, no deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission after deductible
<b>Inpatient Care (including maternity care)</b>	
General hospital care (as many days as medically necessary)	\$275 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	\$275 per admission, no deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible

\* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

\*\* Cost share waived for one breast pump per birth.

\*\*\* Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

† This cost share applies to mental health admissions in a general hospital.

Prescription Drug Benefits*	Your Cost**
At designated retail pharmacies*** (up to a 30-day formulary supply for each prescription or refill)	After deductible \$10 for Tier 1 \$30 for Tier 2 \$65 for Tier 3
Through the designated mail service pharmacy or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)	After deductible \$25 for Tier 1 † \$75 for Tier 2 \$165 for Tier 3

\* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.

\*\* Cost share may be waived for certain covered drugs and supplies.

\*\*\* Specialty drugs available only when obtained from a designated specialty pharmacy.

† Certain generic medications are available through the mail service pharmacy at \$9, no deductible. For more information, go to [bluecrossma.com/mail-service-pharmacy](http://bluecrossma.com/mail-service-pharmacy).

## Get the Most from Your Plan

Visit us at [bluecrossma.com](http://bluecrossma.com) or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

<p><b>Wellness Participation Program</b></p> <p><b>Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs</b> This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs. (See your benefit description for details.)</p> <p><b>Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program</b> This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.)</p>	<p>\$150 per calendar year per policy</p> <p>\$150 per calendar year per policy</p>
24/7 Nurse Care Line—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

## Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at [bluecrossma.com](http://bluecrossma.com).

Interested in receiving information from us via e-mail? Go to [bluecrossma.com/email](http://bluecrossma.com/email) to sign up.

**Limitations and Exclusions.** These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

