



Blue Care[®] Elect \$500 Deductible

with Hospital Choice Cost Sharing

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

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the preferred general hospitals listed in this Summary of Benefits, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital (not listed in this Summary of Benefits) for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.com/hospitalchoice. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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 Choice

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 deductibles for medical benefits are \$500 per member (or \$1,000 per family) for in-network services and \$500 per member (or \$1,000 per family) for out-of-network services. Your deductible for prescription drug benefits is \$100 per member (or \$200 per family).

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your “in-network” benefits. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, you’re still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive some services at or by “higher cost share hospitals,” even if your preferred provider refers you. See the chart for your cost share.

Higher Cost Share Hospitals

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- Baystate Medical Center
- Boston Children’s Hospital
- Brigham and Women’s Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- UMass Memorial Medical Center

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost share may apply.

How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your “out-of-network” benefits. See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider’s actual billed charge (this is in addition to your deductible and/or your coinsurance).

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) for in-network and out-of-network services combined. 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 in-network or out-of-network emergency room services. This copayment is waived if you are 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; consult the Provider Directory; or call the Member Service number on your ID card.

Utilization Review Requirements

Certain services require pre-approval/prior authorization through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don’t get pre-approval when it’s required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

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 In-Network	Your Cost Out-of-Network
Preventive Care Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older 	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including related tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to \$5,000 per ear every 36 months)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for observation stay)	\$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by:		
<ul style="list-style-type: none"> • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, licensed dietitian nutritionist, optometrist, nurse midwife, physician assistant, nurse practitioner, or limited services clinic • Other covered providers 	\$20 per visit, no deductible	20% coinsurance after deductible
	\$60 per visit, no deductible	20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year)	\$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	\$10 per visit, no deductible	20% coinsurance after 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	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$100 per category per service date after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by:		
<ul style="list-style-type: none"> • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, physician assistant, or nurse practitioner • Other covered providers 	\$20 per visit***, no deductible	20% coinsurance after deductible
	\$60 per visit***, no deductible	20% coinsurance after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit		
<ul style="list-style-type: none"> • At other hospitals or by other covered providers • At or by higher cost share hospitals 	\$150 per admission after deductible \$250 per admission after deductible	20% coinsurance after deductible 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.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient Care (including maternity care) in:		
• Other general hospitals (as many days as medically necessary)	\$275 per admission after deductible*	20% coinsurance after deductible
• Higher cost share hospitals (as many days as medically necessary)	\$1,500 per admission after deductible*	20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	\$275 per admission, no deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drug Benefits**	After deductible	Not covered
At designated retail pharmacies*** (up to a 30-day formulary supply for each prescription or refill)†	\$10 for Tier 1 \$30 for Tier 2 \$65 for Tier 3	
Through the designated mail service 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	Not covered

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

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

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

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

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

Get the Most from Your Plan

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

Wellness Participation Program	
Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs 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.)	\$150 per calendar year per policy
Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program 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.)	\$150 per calendar year per policy
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.

Interested in receiving information from us via e-mail? Go to 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.