SUMMARY OF BENEFITS

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.

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An Association of Independent Blue Cross and Blue Shield Plans
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 lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use 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.

How to Find a Preferred Provider
To find a preferred provider:

• Look up a provider on Find a Doctor at bluecrossma.com/findadoctor. 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.org

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.

You must pay a plan-year deductible before you can receive coverage for certain out-of-network benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is $250 per member (or $500 per family).

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your subscriber certificate. 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 $2,000 per member (or $4,000 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). You pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your subscriber certificate (and riders, if any) for exact coverage details.

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 subscriber certificate 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 subscriber certificate (and riders, if any) for exact coverage details.

Domestic Partner Coverage
Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.
## Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Description</th>
<th>Out-of-Network Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child care exams, including routine tests, according to age-based schedule as follows:</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• Ten visits during the first year of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Three visits during the second year of life (age 1 to age 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Two visits for age 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One visit per calendar year for age 3 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests (one per calendar year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Mental health wellness exams (at least one per calendar year)</td>
<td>Nothing</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)</td>
<td>All charges beyond the maximum</td>
<td>20% coinsurance after deductible and all charges beyond the maximum</td>
</tr>
<tr>
<td>Routine vision exams (one per calendar year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Family planning services—office visits</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

## Outpatient Care

### Emergency room visits
- $75 per visit (waived if admitted or for observation stay)
- $75 per visit, no deductible (waived if admitted or for observation stay)

### Office or health center visits, when performed by:
- A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care
- Other covered providers, including a physician assistant or nurse practitioner designated as specialty care
- $20 per visit
- $30 per visit
- $20 per visit

### Mental health or substance use treatment
- $20 per visit

### Outpatient telehealth services
- Same as in-person visit
- Only applicable in-network

### Chiropractors' office visits
- $20 per visit
- $30 per visit
- $20 per visit

### Acupuncture visits (up to 12 visits per calendar year)
- $30 per visit
- $30 per visit
- $30 per visit

### Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)
- $30 per visit
- $30 per visit
- $30 per visit

### Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests
- $30 per visit
- $30 per visit
- $30 per visit

### Home health care and hospice services
- $30 per visit
- $30 per visit
- $30 per visit

### Oxygen and equipment for its administration
- $30 per visit
- $30 per visit
- $30 per visit

### Durable medical equipment—such as wheelchairs, crutches, hospital beds
- 20% coinsurance**
- 40% coinsurance after deductible**
- 20% coinsurance

### Prosthetic devices
- 20% coinsurance
- 40% coinsurance after deductible

### Surgery and related anesthesia in an office or health center, when performed by:
- A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care
- Other covered providers, including a physician assistant or nurse practitioner designated as specialty care
- $20 per visit***
- $30 per visit***

### Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit
- $150 per admission
- $150 per admission
- $150 per admission

## Inpatient Care (including maternity care)

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Description</th>
<th>Out-of-Network Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>General or chronic disease hospital care (as many days as medically necessary)</td>
<td>$250 per admission</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Mental hospital or substance use facility care (as many days as medically necessary)</td>
<td>$250 per admission</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Rehabilitation hospital care (up to 60 days per calendar year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per calendar year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

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* 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.

** In-network cost share waived for one breast pump per birth, including supplies (20% coinsurance after deductible out-of-network).

*** 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.
覆盖服务

### 药物福利

<p>| | | |</p>
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</table>
| At designated retail pharmacies  
(up to a 30-day formulary supply for each prescription or refill)** | $10 for Tier 1  
$30 for Tier 2  
$50 for Tier 3 | Not covered |
| Through the designated mail service pharmacy  
(up to a 90-day formulary supply for each prescription or refill)** | $20 for Tier 1  
$60 for Tier 2  
$100 for Tier 3 | Not covered |

* 一般，Tier 1 指示为通用药物；Tier 2 指示为首选品牌药物；Tier 3 指示为非首选品牌药物。
** 成本分享可能被豁免或减少，对于某些被覆盖的药物和供应品。零售药物在90日供应中可以达到标准零售成本的三倍。

### 如何获得最大的预算

查看 http://bluecrossma.org 或拨打电话 1-888-456-1351，了解有关折扣、节省、资源和特殊项目的详细信息，如下面列出的。

#### 健康参与计划

**健身补偿：**一个奖励参与合格健身项目的计划
(见您的订阅证书了解详情)

$150 每个日历年每个政策

**体重损失补偿：**一个奖励参与合格的体重损失计划的计划
(见您的订阅证书了解详情)

$150 每个日历年每个政策

### 24/7 护士热线

与注册护士交谈，任何时间，获取立即的指导和建议。拨打 1-888-247-BLUE (2583)。无需额外收费。

### 问题？

对于关于 Blue Cross Blue Shield of Massachusetts 的问题，请拨打 1-888-456-1351，
或在线访问 http://bluecrossma.org。
Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

**BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:**

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).

- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscoordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at ocrportal.hhs.gov; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at 1-800-368-1019 or 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov.
PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：711）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitikasyon w lan (Sèvis pou Malantandan TTY: 711).


Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនប្រើអ្នកនិយាយភាសា ខ្មែរ បានជំនួយភាសាសំគិតថ្លៃ គឺអាចរកបានសបរាត្រូវអ្នក។ សូមទូរស័ព្ទបៅខ្្នកបសវាសរាជិកតាមបេ្ បៅបេើ្រ័ណ្ណ សរាគា េ្លៃួនរ្រស់អ្នក (TTY: 711).


Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: 711).


Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: 711).
Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubieganych pod numer podany na identyfikatorze (TTY: 711).

Hindi/हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निश्चित उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टीटीवाई: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: તમે ગુજરાતી બોલતા છો, તો તમામ ભાષાસહી સહાયતા સેવાઓ વિના મૂલ્ય ઉપલબ્ધ છ. તમામ આઈ.ડી. કાર્ડ પર આપણા નંબર પર Member Service ને કૉલ કરો (TTY: 711).


Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: 711）。


Persian/پارسیان: توجه: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اکثریت شما قرار می‌گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش خدمات اعضا تماس بگیرید (TTY: 711).

Lao/ພາສາລາວ: ຂໍ້ ຄວນໃສ່ ໃຈ: ຖ້ າເຈົ້ າເວົ້ າພາສາລາວໄດ້ , ມີ ການບໍ ລິ ການຊ່ ວຍເຫຼື ອດ້ ານພາສາໃຫ້ ທ່ ານໂດຍບໍ ລິ ການສະ ມາ ຊິ ກທີ່ ໝາຍເລກໂທລະສັ ບຢູ່ ໃນບັ ມຂອງທ່ ານ (TTY: 711).