HMO BLUE $500 DEDUCTIBLE

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

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

- Coverage and Benefits
- Claims and Balances
- Digital ID Card

Sign in

Download the app, or create an account at bluecrossma.com.

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 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 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/findadoctor; 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, who is likely affiliated with your PCP’s hospital or medical group. You will not need prior authorization or referral to see a HMO Blue 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 subscriber certificate.

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for some benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is $500 per member (or $1,000 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 $2,000 per member (or $4,000 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). You pay a copayment per visit for 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 mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at wellconnection.com on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. 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.

Service Area
The plan’s service area includes all cities and towns in the Commonwealth of Massachusetts.

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 subscriber certificate 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 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.
<table>
<thead>
<tr>
<th><strong>Covered Services</strong></th>
<th><strong>Your Cost</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>Well-child care visits</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>Nothing, no 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, no deductible</td>
</tr>
<tr>
<td>Routine vision exams (one per calendar year)</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Family planning services—office visits</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>$100 per visit, no deductible (waived if admitted or for observation stay)</td>
</tr>
</tbody>
</table>
| Office or health center visits, when performed by:  
  • Your PCP, OB/GYN physician, nurse midwife, limited services clinic, 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, no deductible  
$30 per visit, no deductible |
| Mental health or substance use treatment | $20 per visit, no deductible  
$20 per visit, no deductible |
| Telehealth services for simple medical conditions or mental health | $20 per visit, no deductible  
$20 per visit, no deductible |
| Chiropractors' office visits (up to 12 visits per calendar year) | $30 per visit, no deductible |
| Acupuncture visits (up to 12 visits per calendar year) | $30 per visit, no deductible |
| Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*) | $30 per visit after deductible  
$30 per visit after deductible |
| Speech, hearing, and language disorder treatment—speech therapy | $30 per visit after deductible  
$30 per visit after deductible |
| Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | Nothing 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 | 20% coinsurance after deductible**  
20% coinsurance after deductible** |
| Prosthetic devices | 20% coinsurance after deductible  
20% coinsurance after deductible |
| Surgery and related anesthesia in an office or health center, when performed by:  
  • Your PCP, OB/GYN physician, nurse midwife, 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***, no deductible  
$30 per visit***, no deductible |
| Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit | Nothing after deductible |
| **Inpatient Care (including maternity care)** |              |
| General or chronic disease hospital care (as many days as medically necessary) | Nothing after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | Nothing after deductible |
| Rehabilitation hospital care (up to 60 days per calendar year) | Nothing after deductible |
| Skilled nursing facility care (up to 100 days per calendar year) | Nothing 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

Prescription Drug Benefits*

| At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)** | No deductible  
$10 for Tier 1  
$30 for Tier 2  
$50 for Tier 3 |
|---|---|
| Through the designated mail order pharmacy (up to a 90-day formulary supply for each prescription or refill)** | No deductible  
$20 for Tier 1***  
$60 for Tier 2  
$100 for Tier 3 |

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

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

*** Certain generic medications are available through the mail order pharmacy at $9. For more information, go to bluecrossma.com/mail-order-pharmacy.

Get the Most from Your Plan: Visit us at bluecrossma.com or call 1-888-456-1351 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program

Fitness Reimbursement: a program that rewards participation in qualified fitness programs

This fitness program applies for fees paid to: a health club with cardiovascular and strength-training equipment; a fitness studio offering instructor-led group classes for cardiovascular and strength-training; or virtual fitness memberships or classes. (See your subscriber certificate for details.)

$150 per calendar year per policy

Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program

This weight loss program 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 subscriber certificate for details.)

$150 per calendar year per policy

24/7 Nurse 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 1-888-456-1351, or visit us online at bluecrossma.com.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate 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 subscriber certificate and riders.

* Registered Marks of the Blue Cross and Blue Shield Association. © 2021 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Printed at Blue Cross and Blue Shield of Massachusetts, Inc.

000836629 (03/21) JM
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, sévis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: 711).

**Vietnamese/Tiếng Việt:** LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: 711).

**Russian/Русский:** ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: 711).

**Arabic/عربية:** انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف). TTY: 711.

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរឬភាសាអយ៉ឺរាល់អំពីមនុស្សមួយចំនួនពៃធ អាចទទួលបានសំណួរការជូនដំណឹងពេលដែលរក្សាសាស្ត្រស្រីប្រសិនបើអ្នកមេរៀនអំពីភាសាអយ៉ឺរាល់ រៀបចំជូនដំណឹងនេះបាន (TTY: 711)។

**French/Français:** ATTENTION : si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d’assuré (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).

**Korean/한국어:** 주의: 한국어를 사용하시는 경우에는 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: 711)를 사용하여 회원 서비스에 전화하십시오.

**Greek/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).