SUMMARY OF BENEFITS

BLUE CARE ELECT PREFERRED

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.org.
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 calendar-year deductible before you can receive coverage
for most out-of-network benefits under this plan. The calendar-year deductible
begins on January 1 and ends on December 31 of each year. Your deductible is
$400 per member (or $800 per family).

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 calendar
year for deductible, copayments, and coinsurance for covered services.
Your out-of-pocket maximums are $2,500 per member (or $5,000 per family)
for in-network services and $2,000 per member (or $4,000 per family) for
out-of-network services.

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.

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, and procedures. 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.
## Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</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>- 10 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>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>All charges beyond the maximum, no deductible</td>
</tr>
<tr>
<td>Routine vision exams (one per calendar year)</td>
<td>$30 per visit</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

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td>$200 per visit</td>
<td>$200 per visit, no deductible</td>
</tr>
<tr>
<td>Office or health center visits, when performed by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 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</td>
<td>$30 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>- Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</td>
<td>$40 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>$30 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Outpatient telehealth services</td>
<td>Same as in-person visit</td>
<td>Same as in-person visit 20% coinsurance after deductible</td>
</tr>
<tr>
<td>Chiropractors' office visits (up to 12 visits per calendar year)</td>
<td>$30 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Acupuncture visits (up to 20 visits per calendar year)</td>
<td>$40 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year for each type of therapy*)</td>
<td>$30 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment—speech therapy</td>
<td>$30 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Durable medical equipment—such as wheelchairs, crutches, hospital beds</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgery and related anesthesia:</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>- Office or health center services</td>
<td>$300 per admission</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

## Inpatient Care (including maternity care)

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>General or chronic disease hospital care (as many days as medically necessary)</td>
<td>$350 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>$350 per admission**</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Rehabilitation hospital care (up to 60 days per calendar year)</td>
<td>$350 per admission**</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per calendar year)</td>
<td>$350 per admission**</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

* 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.
** Copayments limited to $1,000 per member per calendar year for all inpatient admissions.
Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

<table>
<thead>
<tr>
<th>Wellness Participation Program</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)</td>
<td>$150 per calendar year per policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$150 per calendar year per policy</td>
<td></td>
</tr>
</tbody>
</table>

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. 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.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.
TRANSLATION RESOURCES

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 Idantitifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/عربي: اتبع: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على البطاقة الهويسك (جهاز الهاتف). النصي للصم والبكم "TTY" 711.

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរបាន យើងសំរេចសុវត្ថិភាពមិនសិន អ្នកអាចរកបានសំណើអាស្រ័យជាមួយយើងដោយតែសរុបសម្រាប់។ សូមទូរស័ព្ទបរិយាកាស (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).

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association
**Polish/Polski:** UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubiezionech pod numer podany na identyfikatorze (TTY: 711).

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

**Gujarati/ગુજરાતી:** ધ્યાન આપો: તમે ગુજરાતી બોલતા છો, તો તમને ભાષાશાળી સહાયતા સેવાઓ બીના મૂડથી ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપણી નંબરે મંડર ફર મેમ્બર સેવા ના ટર કચરે (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グ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）。

**German/Deutsch:** ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: 711).

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

**Lao/ພາສາລາວ:** ຂໍ້ ຄວນໃສ່ ໃຈ: ຖ້ າເຈົ້ າເວົ້ າພາສາລາວໄດ້, ມີ ການບໍ ລິ ການຊ່ ວຍເຫຼື ອດ້ ານພາສາໃຫ້ ທ່ ານໂດຍ ລາວ, ແບ່ ວ່ ສະ ມາ ຊິ ກທີ່ ໝາຍເລກໂທລະສັ ບຢູ່ ໃນບັ ມ ຜ່ ເຮານ (TTY: 711).

**Navajo/Diné Bizaad:** BAA ÁKOHWIINDZIN DOOÍGI: Diné k’ehjí yáníilt’i’go saad bee yát’i’ éí t’áájíi’k’ee bee ník’a’a’doowolgo éí ná’ahoot’i’. Dií bee aníthigi ninaalthoos bine’déé’ nólomba biká’ígííjí’ béeésh bee hodíílnih (TTY: 711).