SUMMARY OF BENEFITS

BLUE CARE ELECT
$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.org.
Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain 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) for in-network and out-of-network services combined.

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.

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 maximums are $1,500 per member (or $3,000 per family) for in-network services and $3,000 per member (or $6,000 per family) for out-of-network services. Any amount applied toward the in-network out-of-pocket maximum will also be applied toward the out-of-network out-of-pocket maximum (and vice versa).

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 the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. For in-network outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For in-network outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance). To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see “When You Need Help to Find a Health Care Provider” in your benefit description, 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.

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

### Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child care exams, including routine tests</td>
<td>Nothing, no deductible</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</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>Nothing, no deductible</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, no deductible</td>
<td>20% coinsurance after deductible and all charges beyond the maximum</td>
</tr>
<tr>
<td>Routine vision exams</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Family planning services—office visits</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

### Outpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td>$100 per visit, no deductible (waived if admitted or for an observation stay)</td>
<td>$100 per visit, no deductible (waived if admitted or for an observation stay)</td>
</tr>
<tr>
<td>Office or health center visits</td>
<td>$30 per visit, no deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>$30 per visit, no deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Chiropractors’ office visits</td>
<td>Same as in-person visit</td>
<td>Only applicable in-network</td>
</tr>
<tr>
<td>Acupuncture visits (up to 12 visits per calendar year)</td>
<td>$30 per visit, no deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year**)</td>
<td>$30 per visit, no deductible</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 after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Durable medical equipment—such as wheelchairs, crutches, hospital beds</td>
<td>20% coinsurance after deductible***</td>
<td>40% coinsurance after deductible***</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>20% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgery and related anesthesia</td>
<td>$30 per visit†, no deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• Office or health center services</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• Ambulatory surgical facility, hospital outpatient department, or surgical day care unit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Inpatient Care (including maternity care)

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

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* These diabetic services are for diabetes evaluation and management services, diabetic eye exams, or diabetic foot care.
** 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.
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; prescription drugs for use outside of the hospital; 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.

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-486-1136, 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).

**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/дар вели:** انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هوت دايس (جهاز الهاتف للصم والبكم TTY: 711).

**Mon-Khmer, Cambodian/មេសាលាកម្ពុជា:** ការជនដណង៖ ប្រសនប្រអ្នកនយាយភាសា ខ្មែរ បានយោបល់សេរីភាពប្រសាសន៍៖ ធ្វើឱ្យប្រជាជនប្រុស សុខាភិបាលបានប្រាកដុំដឹងអំពីការជនដណង្តោសកម្មារជនកុមារ ដសម្លៃសុខាភិបាល និងសុខាភិបាលអំពីការជនដណង្តោសកម្មារប្រកួតប្រជែងដល់ជនបរទេស (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 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: 711)를 사용하여 회원 서비스에 전화하십시오.

**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 ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

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

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાશાસ્ત્ર સહયોગ સેવાઓ મૂક્ય રાખવામાં આવશે. નમોંદા આઈડી કાર્ડ પર આપિયા નંબર પર Member Service ને કૉલ કરો (TTY: 711).


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