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.com.
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 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.

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
$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 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 $2,500 per member (or $5,000 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
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.

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>
</table>
| Well-child care exams, including routine tests, according to age-based schedule as follows:  
| • 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 | 20% coinsurance after deductible |
| Routine adult physical exams, including related tests (one per calendar year) | Nothing | 20% coinsurance after deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | Nothing | 20% coinsurance after deductible |
| Routine hearing exams, including routine tests | Nothing | 20% coinsurance after deductible |
| Hearing aids (up to $2,500 for one hearing aid or one set of binaural hearing aids per calendar year for a member age 19 or younger) | All charges beyond the maximum | All charges beyond the maximum, no deductible |
| Routine vision exams (one per calendar year) | Nothing | 20% coinsurance after deductible |
| Family planning services–office visits | Nothing | 20% coinsurance after deductible |

### 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 (waived if admitted or for observation stay)</td>
<td>$100 per visit, no deductible (waived if admitted or for observation stay)</td>
</tr>
<tr>
<td>Office or health center visits</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Telehealth services for simple medical conditions or mental health</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Chiropractors’ office visits</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Acupuncture visits (up to 20 visits per calendar year)</td>
<td>$25 per visit</td>
<td>$25 per visit, no deductible</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*)</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>
| CT scans, MRIs, PET scans, and nuclear cardiac imaging tests  
| • Designated Imaging Provider  
| • Hospital or other covered provider | Nothing | 20% coinsurance after deductible |
| Home health care and hospice services         | Nothing | 20% coinsurance after deductible |
| Oxygen and equipment for its administration  | Nothing | 20% coinsurance after deductible |
| Durable medical equipment such as wheelchairs, crutches, hospital beds | Nothing | 20% coinsurance after deductible |
| Prosthetic devices                           | $10% coinsurance** | 20% coinsurance after deductible |
| Surgery and related anesthesia:  
| • Office or health center services  
| • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit | $25 per visit*** | 20% coinsurance after deductible |

### 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</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</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Rehabilitation hospital care (as many days as medically necessary)</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.

** 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.
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.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-882-1093, or visit us online at bluecrossma.com.

Get the Most from Your Plan: Visit us at bluecrossma.com or call 1-800-882-1093 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>$150 per calendar year per policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness Reimbursement: a program that rewards participation in qualified fitness programs</td>
<td></td>
</tr>
<tr>
<td>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 benefit description for details.)</td>
<td></td>
</tr>
</tbody>
</table>

| 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 benefit description 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.

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**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](http://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](http://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: اتتيبا: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هوتوك (جهاز الهاتف الصمي والبكم) 711.

Mon-Khmer, Cambodian/ខ្មែរ: ការជួនដំណឹង៖ ប្រសិនប្រើអ្នកនិយាយភាសាខ្មែរបានសប្បាយការជួនដំណឹងពីវិទ្យាសាស្ត្រប្រជាជនបម្រុង។ សូមប្រឈមសិប្បនិម័យអំពីការជួនដំណឹងនៅក្នុងគុណភាពរបស់អ្នក (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/Λληνικά: 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