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 $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
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.

Value Care Offering Coverage
Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

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.
<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Your Cost In-Network</th>
<th>Your Cost 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                                      | $25 per visit (no cost for routine tests) | 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 |

<table>
<thead>
<tr>
<th>Outpatient Care</th>
<th>Your Cost In-Network</th>
<th>Your Cost 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>Outpatient telehealth services</td>
<td>Same as in-person visit</td>
<td>Same as in-person visit</td>
</tr>
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</tr>
</tbody>
</table>
  - With a covered provider  
  - With the designated telehealth vendor                                          | Nothing              | 20% coinsurance after deductible |
| Acupuncture visits (up to 20 visits per calendar year)                             | $25 per visit        | 20% coinsurance after deductible |
| Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*) | $25 per visit        | 20% coinsurance after deductible |
| Speech, hearing, and language disorder treatment—speech therapy                  | $25 per visit        | 20% coinsurance after deductible |
| Diagnostic X-rays and lab tests                                                  | Nothing              | 20% coinsurance after deductible |
| CT scans, MRIs, PET scans, and nuclear cardiac imaging tests                      | $50 per category per service date | 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            |                      | 10% coinsurance**        |
| Prosthetic devices                                                               | Nothing              | 20% coinsurance after deductible |
| Surgery and related anesthesia                                                   | $25 per visit***     | 20% coinsurance after deductible |
| Inpatient Care (including maternity care)                                         |                      | 20% coinsurance after deductible |
| General or chronic disease hospital care (as many days as medically necessary)    | Nothing              | 20% coinsurance after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | Nothing              | 20% coinsurance after deductible |
| Rehabilitation hospital care (as many days as medically necessary)                | Nothing              | 20% coinsurance after deductible |
| Skilled nursing facility care (up to 100 days per calendar year)                  |                      | 20% coinsurance 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.
Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-882-1093 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

| Wellness Participation Program | $150 per calendar year per policy |
| Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.) |
| Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.) |
| $150 per calendar year per policy |

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 1-800-882-1093, or visit us online at bluecrossma.org.

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.

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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/اللغة العربية: 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/កម្ពុជា: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ បាន សម្រួលអាចរកបានសប្តាហ៍អ្នក។ សូមទូរស័ព្ទបៅខ្្នកបសវាសរាជិកតាមបេ្ (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 ubiegunych pod numer podany na identyfikatorze (TTY: 711).

**Hindi/हिंदी:** ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएं, आप के लिए निःशल्क 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 છો, તો તમને ભાષાસહ્ય સહાયતા સેવાઓ વિના મૂલ્યનું ઉપલબ્ધ છે. તમારા આઇડી કાર্ড પર આપણા નંબર પર મેમ્બર સેવા ને થોડો કરો (TTY: 711).


**Japanese/日本語:** お知らせ：日本語を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）。

**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 به 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:** ຄ່າວໃສ່ ໃຈ: ຖ້າເຈົ້າ ມໍ້າ ມາຊາກ ລາວ ເປັນການບໍລິການຊ່ວຍເຫຼືອດ້ານໂດຍໃຫ້ດ້ວຍໂດຍປະເທດຂອງທ່ານ (TTY: 711).

**Navajo/Diné Bizaad:** BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k’ehjí yáníit’i’go saad bee yát’i’ éí t’aájiik’ee bee nik’á’a’doowolgo éí ná’ahoot’i’. Díí bee anítahígíí nínaaltsoos bine’déé’ n’oomba biká’ígííjí béésh bee hodílnih (TTY: 711).