SUMMARY OF BENEFITS

BLUE CHOICE®
NEW ENGLAND
PLAN 2

UNLOCK THE POWER OF YOUR PLAN
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- CLAIMS AND BALANCES
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MIT – 2023
Choice Plan 2
Your Primary Care Provider (PCP)

When you enroll in this health plan, you choose a primary care provider (PCP) for you and each member of your family. There are a few ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org; consult Find a Doctor at bluecrossma.com/findadoctor; 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 the doctor attended, and whether there are languages other than English spoken in the office.

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. Your provider may also work with Blue Cross Blue Shield of Massachusetts regarding the 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 benefit description.

When You Select an MIT Medical Primary Care Provider (PCP)

When you select an MIT Medical primary care provider as your PCP, your costs will be lower than when you select any other network PCP. For example, you will pay a lower copayment for covered services furnished by either your MIT Medical primary care provider or services furnished by a network specialist when you have an approved referral from your MIT Medical primary care provider. You may have to pay a higher copayment for the same covered services if you selected a network primary care provider who is not part of MIT Medical. For more information, go to http://medweb.mit.edu.

When You Choose to Receive Care on Your Own (Self-Referred)

You have the freedom to seek care without seeing your PCP first. When you seek care on your own from a participating provider, your out-of-pocket cost will be greater. If you require hospitalization, you, or someone on your behalf, will need to call us before you’re admitted to make sure that you’re covered.

You must pay a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. The 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 calendar year for deductible, copayments, and coinsurance for covered services. When your care is provided or arranged by your Blue Cross New England PCP or by your MIT Medical primary care provider (PCP), your out-of-pocket maximum is $2,500 per member (or $5,000 per family). When you choose to receive care on your own (self-referred) from a participating provider, your out-of-pocket maximum is $2,500 per member (or $5,000 per family).

Your Out-of-Pocket Maximum

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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

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.

Service Area


When Outside the Service Area

If you’re traveling outside the plan’s 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. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

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>Covered Services</th>
<th>Your Cost for MIT Medical Primary-Care Approved Benefits</th>
<th>Your Cost for Other Network PCP/Plan-Approved Benefits</th>
<th>Your Cost for Self-Referred/Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-child care exams</td>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing, no deductible*</td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests</td>
<td>Nothing</td>
<td>Nothing</td>
<td></td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing</td>
<td>Nothing</td>
<td></td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>$10 per visit</td>
<td>$20 per visit</td>
<td>$10 per visit when you have an MIT Medical PCP or $20 per visit when you have another PCP, no deductible*</td>
</tr>
<tr>
<td>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)</td>
<td>All charges beyond the maximum</td>
<td>All charges beyond the maximum</td>
<td>All charges beyond the maximum, no deductible*</td>
</tr>
<tr>
<td>Routine vision exam (one per calendar year)</td>
<td>$10 per visit</td>
<td>$20 per visit</td>
<td>$10 per visit when you have an MIT Medical PCP or $20 per visit when you have another PCP, no deductible*</td>
</tr>
<tr>
<td><strong>Family planning services–office visits</strong></td>
<td>Nothing</td>
<td>Nothing</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>$100 per visit (waived if admitted or for observation stay)</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>$10 per visit</td>
<td>$20 per visit</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>$10 per visit</td>
<td>$20 per visit</td>
<td>25% 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>
<td>Same as in-person visit</td>
</tr>
<tr>
<td>• With a covered provider</td>
<td>Nothing</td>
<td>Nothing</td>
<td>Only applicable for MIT Medical Primary–Care Approved and Other Network PCP/Plan–Approved</td>
</tr>
<tr>
<td>• With the MIT Medical Primary–Care Approved and PCP/Plan–Approved designated telehealth vendor</td>
<td>Nothing</td>
<td>Nothing</td>
<td></td>
</tr>
<tr>
<td>Chiropractors’ office visits</td>
<td>$10 per visit</td>
<td>$20 per visit</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Acupuncture visits (up to 20 visits per calendar year)</td>
<td>$10 per visit</td>
<td>$20 per visit</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Short–term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year**)</td>
<td>$10 per visit</td>
<td>$20 per visit</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment–speech therapy</td>
<td>$10 per visit</td>
<td>$20 per visit</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, when performed:</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>• Shields Health Care Group</td>
<td>$50 per category per service date</td>
<td>$50 per category per service date</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>• Other covered providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Durable medical equipment–such as wheelchairs, crutches, hospital beds</td>
<td>10% coinsurance***</td>
<td>10% coinsurance***</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Surgery and related anesthesia</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

* In addition to your cost share, you may be responsible for any balance of charges above the allowed charge.

** No visit limit applies when short–term rehabilitation therapy is furnished as part of covered home health care, treatment of autism spectrum disorders, or speech therapy.

*** MIT Medical PCP and PCP/plan–approved cost share waived for one breast pump per birth, including supplies.
### Covered Services

<table>
<thead>
<tr>
<th>Inpatient Care (including maternity care)</th>
<th>Your Cost for MIT Medical Primary-Care Approved Benefits</th>
<th>Your Cost for Other Network PCP/Plan-Approved Benefits</th>
<th>Your Cost for Self-Referral/Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>General or chronic disease hospital care (as many days as medically necessary)</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% 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>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Rehabilitation hospital care (as many days as medically necessary)</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per calendar year)</td>
<td>Nothing</td>
<td>Nothing</td>
<td>25% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

* In addition to your cost share, you may be responsible for any balance of charges above the allowed charge.

### 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
- **Fitness Reimbursement:** a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)
  - $150 per calendar year per policy
- **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
- **Mind and Body Wellness Program**
  - Reimbursement for participation in the Mind and Body Wellness 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.
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, 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:** انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف تايبي: 711).

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជនដណង៖ ប្រសនប្រអ្នកនយាយភាសា ខ្មែរ បានយោង ដើម្បីជួយការបម្រឹងប្រក្រតេងភាសាឦម៉ះ និងជួយការបម្រឹងប្រក្រតេងភាសាឦម៉ះ (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 सेवाएँ, 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 ભાષાસહયતા સેવાઓ બીઠી મૂળભૂત છે. તમારા આઈડી કાર્ડ પર આપેલ નંબર પર સાથે સેવા નંબર પર Member Service ને કોલ કરો (TTY: 711).


**Japanese/日本語:** お知らせ：日本語でお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 پیروی کارت شناسایی شما قرار می‌گیرد. با شمار تلفن مندرج بر روی کارت شناسایی تماس بگیرید (TTY: 711).

**Lao/ພາສາລາວ:** ເຂດໂປຣເຊັນຈາກຊາວເວລານຊາວ, ກັບແນວໜ້າການຊື່ວຍເຫລືກແຫ່ງຊາດໄດ້ການໂທລະສບຢ່າງໂດຍແປລະກົດ. ແຕ່ມາທາງທີ່ມັກທີ່ການຊື່ວຍເຫລືກທີ່ທີ່ຈາກຄວາມສາມາດໄດ້ປະກວດພາສາທີ່ຮັບຮອງ (TTY: 711).

**Navajo/Diné Bizaad:** BAA ÁKOHWIINDZIN DOÓÍGÍ: Diné k’ehjí yáníít’i’go saad bee yát’i’ éí t’áájiík’é bee nik’a’doowolgo éí ná’ahoot’i’. Díí bee anítahíghi ninaaltsoos bine’déé’ nóomba biká’igííjí’ bée’ésh bee hodíílnih (TTY: 711).