BlueCross BlueShield

SUMMARY OF BENEFITS

PPO Blue Options v.5

This health plan includes a tiered provider network called PPO Blue Options v.5. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **www.bluecrossma.com/findadoctor** and search for PPO Blue Options v.5.

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

This plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

Your Choice

When You Choose Preferred Providers

You have the option of selecting in-network providers who are part of the PPO Blue Options network (preferred providers). You'll generally receive a higher level of benefits—and pay lower out-of-pocket costs—when you choose preferred providers. See the charts for your cost share.

Within the network, certain preferred primary care providers and preferred general hospitals are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier preferred providers each time you get care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes preferred providers in Massachusetts that meet the standards for quality and are low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.
- **Standard Benefits Tier**—Includes preferred providers in Massachusetts that meet the standards for quality and moderate cost relative to our benchmark. This benefits tier includes preferred hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.
- **Basic Benefits Tier**—Includes preferred hospitals in Massachusetts that are high cost relative to our benchmark. Also includes preferred primary care providers in Massachusetts who did not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pocket costs when you choose providers in the Basic Benefits Tier.

Note: Primary care providers were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Preferred providers without sufficient data for cost and quality are placed in the Standard Benefits Tier. Preferred primary care providers that do not meet benchmarks for one or both of the domains and preferred hospitals that do not meet benchmarks for cost or that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your provider and the facility where your provider has admitting privileges before you choose a preferred primary care provider or receive care. For example, if you require hospital care and your Enhanced Benefits Tier preferred primary care provider refers you to an Enhanced Benefits Tier preferred hospital, you would pay the lowest cost sharing for both your provider and hospital services. Or, if your Enhanced Benefits Tier preferred primary care provider refers you to a Basic Benefits Tier preferred hospital for care, you will pay the lowest copayments for preferred primary care provider services, but the highest copayments for hospital services, except in an emergency.

How to Find a Preferred Provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com/findadoctor**
- Call the Physician Selection Service at **1-800-821-1388**

Note: In some out-of-state PPO service areas, different levels of preferred providers may not be available. In this case, your cost share will be the same as it would be for an Enhanced Benefits Tier preferred provider.

When You Choose Non-Preferred Providers

You can also obtain covered services from out-of-network providers (non-preferred providers), but your out-of-pocket costs are higher. See the charts for your cost share.

Your deductible is the amount of money you pay out-of-pocket each calendar year before you can receive coverage for most benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible is **$150** per member (or **$300** per family).

Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts 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 maximum for medical benefits is **$2,500** per member (or **$5,000** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

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. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital.

Utilization Review Requirements

Certain services require pre-approval 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, procedures (such as MRIs and CT Scans), and drugs. You should work with your provider to determine if pre-approval is required. If your provider, or you, do not get pre-approval when it is required, your benefits will be reduced or denied, and you may be fully responsible for payment to the service provider. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval (for certain outpatient services), 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.

Your Medical Benefits

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care Routine physical exams, including related 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 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 $5,000 per ear every 36 months)	All charges beyond the maximum	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exam (one every 24 months)	Nothing	20% coinsurance after deductible
Family planning services–office visits	Nothing	20% coinsurance after deductible
Outpatient Care Emergency room visits	$50 per visit (waived if admitted or for observation stay)	$50 per visit, no deductible (waived if admitted or for observation stay)
Primary care provider visits at an office or health center	Enhanced Benefits Tier: $10 per visit Standard Benefits Tier: $15 per visit Basic Benefits Tier: $20 per visit	20% coinsurance after deductible
Specialists and other covered provider visits	$25 per visit	20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$15 per visit	20% coinsurance after deductible
Mental health or substance abuse treatment	$10 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 90 visits per calendar year*)	$15 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$15 per visit	20% coinsurance after deductible
Diagnostic X-rays and lab tests, including MRIs, CT scans, PET scans, and nuclear cardiac imaging tests	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	Nothing	20% coinsurance after deductible
Surgery and related anesthesia, when performed: • In an office setting	Enhanced Benefits Tier: $10 per visit** Standard Benefits Tier: $15 per visit** Basic Benefits Tier: $20 per visit** Other covered provider: $25 per visit**	20% coinsurance after deductible
• At an ambulatory surgical facility, hospital, or surgical day care unit	All Tiers: $100 per admission	20% coinsurance after deductible
Inpatient Care (and maternity care) General hospital care (as many days as medically necessary)	Enhanced Benefits Tier: $200 per admission*** Standard Benefits Tier: $400 per admission*** Basic Benefits Tier: $400 per admission***	20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	$200 per admission	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$200 per admission	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing	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.
** 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.
*** This cost share applies to mental health admissions in a general hospital.

Prescription Drug Benefits*	Your Cost In-Network**	Your Cost Out-of-Network
At retail pharmacies*** (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1 $20 for Tier 2 $40 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1† $40 for Tier 2 $90 for Tier 3	Not covered

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.
** Cost share may be waived for certain covered drugs and supplies.
*** Specialty drugs available only when obtained from a designated specialty pharmacy.
† Certain generic medications are available through the mail service pharmacy at $9. For more information, go to www.bluecrossma.com/mail-service-pharmacy.

Get the Most from Your Plan

Visit us at **www.bluecrossma.com** or call **1-800-782-3675** to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	$150 per calendar year per policy
Blue Care Line®—A 24-hour nurse line to answer your health care questions—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 **www.bluecrossma.com**. Interested in receiving information from us via e-mail? Go to **www.bluecrossma.com/email** to sign up.

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; 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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BlueCross® BlueShield®

MASSACHUSETTS

Nondiscrimination Notice

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**.

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MASSACHUSETTS

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 Idantitifkasyon 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/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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 हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क 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 ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (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:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

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