MASSACHUSETTS

PRODUCT BENEFITS AND
COVERAGE OPTIONS FOR 2021

GETTING MORE. NOW THERE'S A PLAN.

2–50 HMO & PPO

Accounts with 2–50 Enrolled Subscribers and 50 or Fewer Full-Time Employees
Effective on anniversary dates on or after January 1, 2021

4 YEARS IN A ROW

We've ranked "Highest in Member Satisfaction among Commercial Health Plans in Massachusetts" by J.D. Power in 2017, 2018, 2019, and 2020.

PLANS THAT FIT YOUR EMPLOYEES' NEEDS

Selecting a health plan should be easy, and you should feel confident about the plan you choose for your employees. With the largest network of providers in the country, we're able to consistently offer the lowest total cost of care, as well as exceptional health care experiences.

Use the charts and information in this brochure to compare the benefits included in each of our plans,* so you can find the right option for your employees.

STAY INFORMED WITH PLAN CHANGES FOR 2021

We want to keep you well informed about our plan offerings, so you and your employees avoid any surprises. Our enhanced plan benefits** are designed to maximize your employees' coverage while maintaining low costs. These changes for 2021 ensure that we're up-to-date with health care reform guidelines, while we continue to give your employees reliable access to the care they need.

* Our plans feature more benefits than those listed here. To see more details about what's included in each plan, refer to the plan subscriber certificates.
** Effective January 1, 2021, and upon renewal, unless otherwise noted.

NEW PLAN DESIGNS FOR 2021

We're pleased to introduce the following new plan designs, effective January 1, 2021:

- **Preferred Blue PPO $1,500 Deductible** plan offers members a deductible plan option that's designed to keep their costs low.
- **HMO Blue New England Total Deductible with Rx** plan has no coinsurance, and copayments for prescription drugs only, which provides more predictable costs for members. With this plan, the deductible amount is equal to the out-of-pocket maximum, and members won't have to pay for covered medical services once they meet their deductible.

Use the charts on the following pages to learn more about the benefits included in these new plans.

THE AFFORDABLE CARE ACT (ACA) OUT-OF-POCKET MAXIMUM AND INTERNAL REVENUE SERVICE (IRS) COST-OF-LIVING ADJUSTMENTS FOR 2021

Most health plans must include an out-of-pocket maximum that limits costs for all Essential Health Benefits, including pharmacy. Out-of-pocket costs include copays, coinsurance, and deductibles.

Our standard health plans include an out-of-pocket maximum that's set at or below the ACA's limits and the IRS's guidelines for Health Savings Account (HSA)-compatible, high-deductible plans.

ANNUAL OUT-OF-POCKET MAXIMUMS FOR 2021

Plan Type	Individual Coverage	Family Coverage
HSA QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS	$7,000	$14,000
NON-HSA QUALIFIED HEALTH PLANS	$8,550	$17,100

MINIMUM DEDUCTIBLE AMOUNTS FOR 2021

Plan Type	Individual Coverage	Family Coverage
HSA QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS	$1,400	$2,800

COST SHARE CHANGES FOR 2021

Changes to cost-sharing amounts are due to a variety of factors, such as needing to meet the requirements set by the Affordable Care Act. All changes are noted in the charts on the following pages, or members can check their Summary of Benefits to review the cost-sharing amounts and benefit changes that might affect their plan.

Changes for 2021	Details
HMO & PPO: INCREASE OVERALL MAXIMUM OUT-OF-POCKET AMOUNTS	Increase in-network maximum out-of-pocket amounts across most Small Group 2021 plans to: • Non-HSA plans: $8,150 / $16,300 • HSA Qualified plans (Saver plans): $6,900 / $13,800
PPO: INCREASE INPATIENT COINSURANCE TO 10%	• Increase PPO inpatient cost share to 10% coinsurance after deductible on all Small Group PPO plans
PPO: INCREASE MAXIMUM OUT-OF-POCKET AMOUNTS	• Increase out-of-network maximum out-of-pocket amount to be twice the in-network maximum out-of-pocket amount across most PPO Small Group plans
PPO: INCREASE OUT-OF-NETWORK DEDUCTIBLE AMOUNTS	• Where applicable, increase out-of-network deductible amounts for PPO plans to $3,000 greater than the in-network deductible

UNLOCK THE POWER OF OUR PLANS

One of the most important benefits of a health plan is getting assistance and advice. So no matter which plan your employees choose, we make sure it comes with the helpful tools of MyBlue, and the helpful people of Team Blue. Together, they make Massachusetts' most trusted medical plans more powerful than ever.

THE BEST HEALTH INSURANCE IS THE KIND YOU UNDERSTAND

Hospital Choice Cost Sharing (indicated by orange)

These HMO or PPO health plan designs include the Hospital Choice Cost Sharing feature, which means members will pay different costs depending on where they get care. With Hospital Choice Cost Sharing, members are empowered to get the most out of their plan by choosing more cost-effective providers and hospitals.[8] For more information, visit **bluecrossma.com/hospitalchoice** or contact your account executive or broker.

Blue Options (indicated by gray)

These HMO or PPO health plans include a tiered provider network called "HMO Blue New England Options v.5" or "Preferred Blue PPO Options v.5". In each network, we place providers into three tiers based on cost and quality. Members pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on which tier their provider is in. A provider's tier may change, but overall tier changes will happen no more than once each calendar year. To find a provider's tier, use our online Find a Doctor tool at **bluecrossma.com/findadoctor** and select "HMO Blue New England Options v.5" or "Preferred Blue PPO Options v.5".

Blue Select (indicated by blue)

These HMO health plans include a limited provider network called HMO Blue Select, which is smaller than the Blue Cross Blue Shield of Massachusetts HMO Blue provider network. Under these plans, members can get care from only the providers in the HMO Blue Select network. To see which providers are included in the HMO Blue Select network, use our online Find a Doctor tool at **bluecrossma.com/findadoctor** and select "HMO Blue Select".

HMO

Accounts with 2–50 Enrolled Subscribers and 50 or Fewer Full-Time Employees

	HMO Blue New England Premier Value	HMO Blue New England $500 Deductible with Hospital Choice Cost Sharing	HMO Blue New England $1,000 Deductible with Hospital Choice Cost Sharing
DEDUCTIBLE[2]	Inpatient: $1,000/$2,500	$500/$1,000	$1,000/$2,000
OUT-OF-POCKET MAXIMUM[3]	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300
OFFICE VISIT	Preventive: $0 PCP[1]: $25 Specialist[1]: $45	Preventive: $0 PCP[1]: $25 Specialist[1]: $45	Preventive: $0 PCP[1]: $25 Specialist[1]: $45
EMERGENCY ROOM	$250	$150	$250
INPATIENT ADMISSIONS	Deductible	Deductible	Deductible
SURGICAL DAY CARE	$500	Deductible	Deductible
LABS[7]	Hospital: $40 Other network provider: $0	$35 after deductible	$35 after deductible
X-RAYS[7]	Hospital: $40 Other network provider: $0	$35 after deductible	$35 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Hospital: $300 Other network provider: $50	Deductible	$75 after deductible
PRESCRIPTION DRUGS	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $70 X-rays and other imaging tests: $135 MRI/CT/PET/NC: $450 PT/OT/ST: $80	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $70 X-rays and other imaging tests: $135 MRI/CT/PET/NC: $525 PT/OT/ST: $80

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier
SDC: Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England $1,000 Deductible with Copayment	HMO Blue Select $1,000 Deductible	HMO Blue New England $1,500 Deductible with Hospital Choice Cost Sharing
DEDUCTIBLE[2]	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000
OUT-OF-POCKET MAXIMUM[3]	$8,100/$16,200	$8,150/$16,300	$8,150/$16,300
OFFICE VISIT	Preventive: $0 PCP[1]: $25 Specialist[1]: $50	Preventive: $0 PCP[1]: $25 Specialist[1]: $45	Preventive: $0 PCP[1]: $25 Specialist[1]: $45
EMERGENCY ROOM	$250	$250	$250
INPATIENT ADMISSIONS	$550 after deductible	Deductible	Deductible
SURGICAL DAY CARE	$250 after deductible	Deductible	Deductible
LABS[7]	Hospital: $40 after deductible Other network provider: Deductible	$40 after deductible	$35 after deductible
X-RAYS[7]	Hospital: $80 after deductible Other network provider: Deductible	$40 after deductible	$35 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Hospital: $300 after deductible Other network provider: $50 after deductible	$75 after deductible	$75 after deductible
PRESCRIPTION DRUGS	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $70 X-rays and other imaging tests: $135 MRI/CT/PET/NC: $525 PT/OT/ST: $80

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England $2,000 Deductible	HMO Blue New England Options Deductible II v.5[9]	HMO Blue New England $2,000 Deductible with Hospital Choice Cost Sharing
DEDUCTIBLE[2]	$2,000/$4,000	$1,000/$2,000	$2,000/$4,000
OUT-OF-POCKET MAXIMUM[3]	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300
OFFICE VISIT	Preventive: $0 PCP[1]: $25 Specialist[1]: $45	Preventive: $0 PCP[1]: EBT: $25 SBT: $40 BBT: $55 Specialist[1]: $55	Preventive: $0 PCP[1]: $25 Specialist[1]: $45
EMERGENCY ROOM	$250	$350	$150
INPATIENT ADMISSIONS	Deductible	EBT: Deductible SBT: $750 after deductible ($50 after deductible for select hospitals[10]) BBT: $2,000 after deductible	Deductible
SURGICAL DAY CARE	Deductible	EBT: Deductible SBT: $750 after deductible ($50 after deductible for select hospitals[10]) BBT: $2,000 after deductible	Deductible
LABS[7]	Hospital: $60 after deductible Other network provider: Deductible	EBT: $15 after deductible SBT: $50 after deductible BBT: $70 after deductible Other network provider: $15	$35 after deductible
X-RAYS[7]	Hospital: $100 after deductible Other network provider: Deductible	EBT: $15 after deductible SBT: $50 after deductible BBT: $70 after deductible Other network provider: $15	$35 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Hospital: $300 after deductible Other network provider: $50 after deductible	EBT: Deductible SBT: $150 after deductible BBT: $500 after deductible Other network provider: $0	$50 after deductible
PRESCRIPTION DRUGS	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB[1]: $10/$45/$175/$750	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $70 X-rays and other imaging tests: $135 MRI/CT/PET/NC: $500 PT/OT/ST: $80

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

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	HMO Blue Select $1,000 Deductible with Copayment	HMO Blue Select $2,000 Deductible	HMO Blue New England Options Deductible III v.5[9]
DEDUCTIBLE[2]	$1,000/$2,000	$2,000/$4,000	$2,000/$4,000
OUT-OF-POCKET MAXIMUM[3]	$7,450/$14,900	$8,150/$16,300	$8,150/$16,300
OFFICE VISIT	Preventive: $0 PCP[1]: $25 Specialist[1]: $50	Preventive: $0 PCP[1]: $25 Specialist[1]: $45	Preventive: $0 PCP[1]: EBT: $25 SBT: $40 BBT: $55 Specialist[1]: $55
EMERGENCY ROOM	$250	$250	$350
INPATIENT ADMISSIONS	$550 after deductible	Deductible	EBT: Deductible SBT: $750 after deductible ($50 after deductible for select hospitals[10]) BBT: $2,000 after deductible
SURGICAL DAY CARE	$250 after deductible	Deductible	EBT: Deductible SBT: $750 after deductible ($50 after deductible for select hospitals[10]) BBT: $2,000 after deductible
LABS[7]	$60 after deductible	$15 after deductible	EBT: $15 after deductible SBT: $50 after deductible BBT: $70 after deductible Other network provider: $15
X-RAYS[7]	$60 after deductible	$15 after deductible	EBT: $15 after deductible SBT: $50 after deductible BBT: $70 after deductible Other network provider: $15
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	$250 after deductible	$75 after deductible	EBT: Deductible SBT: $150 after deductible BBT: $500 after deductible Other network provider: $0
PRESCRIPTION DRUGS	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB[1]: $10/$45/$175/$750
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England $2,000 Deductible with Copayment	NEW HMO Blue New England Total Deductible with Rx	HMO Blue New England $3,000 Deductible
DEDUCTIBLE[2]	$2,000/$4,000	$3,500/$7,000	$3,000/$6,000
OUT-OF-POCKET MAXIMUM[3]	$8,150/$16,300	$3,500/$7,000	$8,150/$16,300
OFFICE VISIT	Preventive: $0 PCP[1]: $25 Specialist[1]: $45	Preventive: $0 PCP[1]: Deductible Specialist[1]: Deductible	Preventive: $0 PCP[1]: $40 Specialist[1]: $55
EMERGENCY ROOM	$750 after deductible	Deductible	$750 after deductible
INPATIENT ADMISSIONS	$550 after deductible	Deductible	$500 after deductible
SURGICAL DAY CARE	$250 after deductible	Deductible	$500 after deductible
LABS[7]	Hospital: $80 after deductible Other network provider: Deductible	Deductible	Hospital: $60 after deductible Other network provider: Deductible
X-RAYS[7]	Hospital: $125 after deductible Other network provider: Deductible	Deductible	Hospital: $100 after deductible Other network provider: Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Hospital: $350 after deductible Other network provider: $75 after deductible	Deductible	Hospital: $300 after deductible Other network provider: $50 after deductible
PRESCRIPTION DRUGS	Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB[1]: $10/$45/$175/$750	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

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	HMO Blue New England Saver $2,000 (HSA Compliant)	HMO Blue New England Basic Copayment	HMO Blue New England $3,000 Deductible with Hospital Choice Cost Sharing
DEDUCTIBLE[2]	$2,000/$4,000[4]	$2,000/$4,000	$3,000/$6,000
OUT-OF-POCKET MAXIMUM[3]	$6,900/$13,800	$8,150/$16,300	$8,150/$16,300
OFFICE VISIT	Preventive: $0 PCP[1]: $25 after deductible Specialist[1]: $45 after deductible	Preventive: $0 PCP[1]: $40 Specialist[1]: $60	Preventive: $0 PCP[1]: $30 Specialist[1]: $40
EMERGENCY ROOM	$250 after deductible	$1,000 after deductible	$500 after deductible
INPATIENT ADMISSIONS	$250 after deductible	$1,000 after deductible	$500 after deductible
SURGICAL DAY CARE	$250 after deductible	$1,000 after deductible	$500 after deductible
LABS[7]	Hospital: $60 after deductible Other network provider: Deductible	Hospital: $60 after deductible Other network provider: Deductible	$35 after deductible
X-RAYS[7]	Hospital: $100 after deductible Other network provider: Deductible	Hospital: $100 after deductible Other network provider: Deductible	$40 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Hospital: $400 after deductible Other network provider: $75 after deductible	Hospital: $1,000 after deductible Other network provider: $750 after deductible	$500 after deductible
PRESCRIPTION DRUGS	After deductible[6] Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB[1]: $10/$45/$175/$750	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	After deductible Inpatient: $1,500 SDC: $1,500 Labs: $70 X-rays and other imaging tests: $140 MRI/CT/PET/NC: $950 PT/OT/ST: $75

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England $4,500 Deductible	HMO Blue Select $2,000 Deductible with Copayment	HMO Blue New England Saver $3,000 (HSA Compliant)
DEDUCTIBLE[2]	$4,500/$9,000	$2,000/$4,000	$3,000/$6,000[5]
OUT-OF-POCKET MAXIMUM[3]	$8,150/$16,300	$8,150/$16,300	$6,900/$13,800
OFFICE VISIT	Preventive: $0 PCP[1]: $40 Specialist[1]: $55	Preventive: $0 PCP[1]: $25 Specialist[1]: $45	Preventive: $0 PCP[1]: $35 after deductible Specialist[1]: $50 after deductible
EMERGENCY ROOM	$500 after deductible	$750 after deductible	$250 after deductible
INPATIENT ADMISSIONS	$500 after deductible	$500 after deductible	Deductible
SURGICAL DAY CARE	$500 after deductible	$250 after deductible	Deductible
LABS[7]	Hospital: $60 after deductible Other network provider: Deductible	$55 after deductible	Hospital: $35 after deductible Other network provider: Deductible
X-RAYS[7]	Hospital: $100 after deductible Other network provider: Deductible	$55 after deductible	Hospital: $35 after deductible Other network provider: Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Hospital: $300 after deductible Other network provider: $50 after deductible	$200 after deductible	Hospital: $150 after deductible Other network provider: Deductible
PRESCRIPTION DRUGS	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB[1]: $10/$45/$175/$750	After deductible[6] Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier
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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue Select $3,000 Deductible	HMO Blue Select Saver $2,000 (HSA Compliant)	HMO Blue New England Saver $3,000 with Hospital Choice Cost Sharing (HSA Compliant)
DEDUCTIBLE[2]	$3,000/$6,000	$2,000/$4,000[4]	$3,000/$6,000[5]
OUT-OF-POCKET MAXIMUM[3]	$8,150/$16,300	$6,900/$13,800	$6,900/$13,800
OFFICE VISIT	Preventive: $0 PCP[1]: $40 Specialist[1]: $55	Preventive: $0 PCP[1]: $25 after deductible Specialist[1]: $45 after deductible	Preventive: $0 PCP[1]: $35 after deductible Specialist[1]: $50 after deductible
EMERGENCY ROOM	$750 after deductible	$250 after deductible	$250 after deductible
INPATIENT ADMISSIONS	$500 after deductible	$250 after deductible	Deductible
SURGICAL DAY CARE	$500 after deductible	$150 after deductible	Deductible
LABS[7]	$40 after deductible	$40 after deductible	Deductible
X-RAYS[7]	$40 after deductible	$40 after deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	$300 after deductible	$250 after deductible	Deductible
PRESCRIPTION DRUGS	Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675	After deductible[6] Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB[1]: $10/$45/$175/$750	After deductible[6] Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB[1]: $10/$45/$150/$675
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays and other imaging tests: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $80

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier
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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England Saver $4,500 (HSA Compliant)	HMO Blue New England Basic Saver (HSA Compliant)
DEDUCTIBLE[2]	$4,500/$9,000[5]	$3,350/$6,550[5]
OUT-OF-POCKET MAXIMUM[3]	$6,350/$12,700	$6,550/$13,100
OFFICE VISIT	Preventive: $0 PCP[1]: $35 after deductible Specialist[1]: $50 after deductible	Preventive: $0 PCP[1]: $40 after deductible Specialist[1]: $60 after deductible
EMERGENCY ROOM	$250 after deductible	$1,000 after deductible
INPATIENT ADMISSIONS	$250 after deductible	$1,000 after deductible
SURGICAL DAY CARE	$250 after deductible	$1,000 after deductible
LABS[7]	Hospital: $35 after deductible Other network provider: Deductible	Hospital: $80 after deductible Other network provider: Deductible
X-RAYS[7]	Hospital: $35 after deductible Other network provider: Deductible	Hospital: $125 after deductible Other network provider: Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Hospital: $150 after deductible Other network provider: Deductible	Hospital: $1,000 after deductible Other network provider: $750 after deductible
PRESCRIPTION DRUGS	After deductible[6] Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB[1]: $10/$45/$175/$750	After deductible[6] Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB[1]: $10/$45/$175/$750
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT | INDICATES CHANGES TO PLAN

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FOOTNOTES LOCATED ON THE LAST PAGE

PPO

Accounts with 2–50 Enrolled Subscribers and 50 or Fewer Full-Time Employees

	NEW Preferred Blue® PPO $1,500 Deductible	Preferred Blue® PPO $2,000 Deductible	Preferred Blue® PPO $2,000 Deductible with Hospital Choice Cost Sharing
DEDUCTIBLE[2]	IN: $1,500/$3,000 OON: $4,500/$9,000	IN: $2,000/$4,000 OON: $5,000/$10,000	IN: $2,000/$4,000 OON: $5,000/$10,000
OUT-OF-POCKET MAXIMUM[3]	IN: $8,150/$16,300 OON: $16,300/$32,600	IN: $8,150/$16,300 OON: $16,300/$32,600	IN: $8,150/$16,300 OON: $16,300/$32,600
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $25 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $35 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $35 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$200 after in-network deductible	$250 after in-network deductible	$250 after in-network deductible
INPATIENT ADMISSIONS	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE	IN: $250 after deductible OON: 20% coinsurance after deductible	IN: $250 after deductible OON: 20% coinsurance after deductible	IN: $250 after deductible OON: 20% coinsurance after deductible
LABS[7]	IN: Hospital: $60 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $60 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: $35 after deductible OON: 20% coinsurance after deductible
X-RAYS[7]	IN: Hospital: $80 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $100 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: $35 after deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: Hospital: $120 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $400 after deductible Other Network Provider: $75 after deductible OON: 20% coinsurance after deductible	IN: $250 after deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB: $10/$45/$150/$675 OON: Retail: $20/$90/$300/$450 Mail: Not covered	IN: Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB: $10/$45/$150/$675 OON: Retail: $20/$90/$300/$450 Mail: Not covered	IN: Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB: $10/$45/$150/$675 OON: Retail: $20/$90/$300/$450 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	After deductible Inpatient: 20% coinsurance SDC: $1,250 Labs: $70 X-rays after deductible: $135 MRI/CT/PET/NC: $700 PT/OT/ST: $80

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier
SDC: Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue® PPO Saver $2,000 (HSA Compliant)	Preferred Blue® PPO $3,000 Deductible	Preferred Blue® PPO $3,000 Deductible with Hospital Choice Cost Sharing
DEDUCTIBLE[2]	IN: $2,000/$4,000[4] OON: $5,000/$10,000[4]	IN: $3,000/$7,500 OON: $6,000/$13,000	IN: $3,000/$7,500 OON: $6,000/$13,000
OUT-OF-POCKET MAXIMUM[3]	IN: $6,900/$13,800 OON: $13,800/$27,600	IN: $8,150/$16,300 OON: $16,300/$32,600	IN: $8,150/$16,300 OON: $16,300/$32,600
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $30 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 Primary Care[1]: $35 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $35 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$250 after in-network deductible	$500 after in-network deductible	$500 after in-network deductible
INPATIENT ADMISSIONS	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE	IN: $250 after deductible OON: 20% coinsurance after deductible	IN: $500 after deductible OON: 20% coinsurance after deductible	IN: $500 after deductible OON: 20% coinsurance after deductible
LABS[7]	IN: Hospital: $60 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $40 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: $35 after deductible OON: 20% coinsurance after deductible
X-RAYS[7]	IN: Hospital: $80 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $60 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: $35 after deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: Hospital: $400 after deductible Other Network Provider: $75 after deductible OON: 20% coinsurance after deductible	IN: Hospital: $400 after deductible Other Network Provider: $75 after deductible OON: 20% coinsurance after deductible	IN: $250 after deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	After in-network deductible[6] IN: Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB: $10/$45/$175/$750 After out-of-network deductible[6] OON: Retail: $20/$90/$350/$500 Mail: Not covered	IN: Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB: $10/$45/$175/$750 OON: Retail: $20/$90/$350/$500 Mail: Not covered	IN: Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB: $10/$45/$175/$750 OON: Retail: $20/$90/$350/$500 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	After deductible Inpatient: 20% coinsurance SDC: $1,500 Labs: $70 X-rays and other imaging tests: $135 MRI/CT/PET/NC: $700 PT/OT/ST: $80

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier
SDC: Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue® PPO Saver $3,000 (HSA Compliant)	Preferred Blue® PPO $4,500 Deductible
DEDUCTIBLE[2]	IN: $3,000/$6,000[5] OON: $6,000/$12,000[5]	IN: $4,500/$9,000 OON: $7,500/$15,000
OUT-OF-POCKET MAXIMUM[3]	IN: $6,900/$13,800 OON: $13,800/$27,600	IN: $8,150/$16,300 OON: $16,300/$32,600
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $30 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 Primary Care[1]: $35 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$150 after in-network deductible	$1,000 after in-network deductible
INPATIENT ADMISSIONS	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE	IN: $250 after deductible OON: 20% coinsurance after deductible	IN: $500 after deductible OON: 20% coinsurance after deductible
LABS[7]	IN: Hospital: $40 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $100 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible
X-RAYS[7]	IN: Hospital: $40 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $250 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: Hospital: $400 after deductible Other Network Provider: $75 after deductible OON: 20% coinsurance after deductible	IN: Hospital: $400 after deductible Other Network Provider: $75 after deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	After in-network deductible[6] IN: Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB: $10/$45/$150/$675 After out-of-network deductible[6] OON: Retail: $20/$90/$300/$450 Mail: Not covered	IN: Retail: $10/$45/$150/$225 Mail: $20/$90/$300/$675 VBB: $10/$45/$150/$675 OON: Retail: $20/$90/$300/$450 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier
SDC: Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue® PPO Saver $4,500 (HSA Compliant)	Preferred Blue® PPO Basic Saver (HSA Compliant)
DEDUCTIBLE[2]	IN: $4,500/$9,000[5] OON: $7,500/$15,000[5]	IN: $3,350/$6,550[5] OON: $6,350/$12,700[5]
OUT-OF-POCKET MAXIMUM[3]	IN: $6,350/$12,700 OON: $12,700/$25,400	IN: $6,550/$13,100 OON: $13,100/$26,200
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $30 after deductible Specialist[1]: $45 after deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 Primary Care[1]: $40 after deductible Specialist[1]: $60 after deductible OON: 20% coinsurance after deductible (no deductible for preventive care)
EMERGENCY ROOM	$150 after in-network deductible	$1,000 after in-network deductible
INPATIENT ADMISSIONS	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE	IN: $500 after deductible OON: 20% coinsurance after deductible	IN: $1,000 after deductible OON: 20% coinsurance after deductible
LABS[7]	IN: Hospital: $40 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $80 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible
X-RAYS[7]	IN: Hospital: $40 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible	IN: Hospital: $125 after deductible Other Network Provider: Deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: Hospital: $400 after deductible Other Network Provider: $75 after deductible OON: 20% coinsurance after deductible	IN: Hospital: $1,000 after deductible Other Network Provider: $750 after deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	After in-network deductible[6] IN: Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB: $10/$45/$175/$750 After out-of-network deductible[6] OON: Retail: $20/$90/$350/$500 Mail: Not covered	After in-network deductible[6] IN: Retail: $10/$45/$175/$250 Mail: $20/$90/$350/$750 VBB: $10/$45/$175/$750 After out-of-network deductible[6] OON: Retail: $20/$90/$350/$500 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING BLUE OPTIONS

INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier
SDC: Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

FOOTNOTES LOCATED ON THE LAST PAGE

Medicare Creditable Coverage

All plans in this chart meet Medicare Creditable Coverage prescription drug coverage requirements, except HMO Blue New England Saver $4,500 and Preferred Blue PPO Saver $4,500. Creditable Coverage means that the member's prescription drug coverage is as good as or better than the standard Medicare Part D plan.

Minimum Creditable Coverage

All plans in this chart meet the minimum level of benefits that adult tax filers need to be considered insured and avoid tax penalties in Massachusetts.

Low-Cost Generic Drug Benefit

With all plans, members can get a 90-day supply of select generic medications for only $9 when filled through Express Scripts® (ESI), our mail order pharmacy. Normal prescription guidelines apply.

Select Home Delivery

Members in plans with Select Home Delivery need to select whether they want to fill their maintenance medications through the mail order pharmacy ESI, or at a retail pharmacy. Members who fill their prescriptions through ESI can save time and money on a 90-day supply of their medications. Members who choose to fill their prescriptions at a retail pharmacy need to notify ESI before their third medication fill, or they will be responsible for the full cost of their medication. Select Home Delivery is included in all plans listed in this guide.

Value-Based Benefits[1]

This approach to managing costs focuses on improving the health of members who have certain chronic conditions. These benefits are included in some plans listed in this guide.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS ALLOWS SMALL EMPLOYER GROUPS[11] WITH TWO OR MORE ENROLLED EMPLOYEES TO OFFER UP TO TWO MEDICAL PLANS.

Please see our Underwriting Guidelines for this type of arrangement:

- The Hospital Choice Cost Sharing feature (HCCS or Options) can only be offered alongside another product with the Hospital Choice Cost Sharing feature (HCCS or Options) or alongside a Saver product.
- Products without the Hospital Choice Cost Sharing feature (Non-HCCS or Non-Options) can only be offered alongside products without the Hospital Choice Cost Sharing feature (Non-HCCS or Non-Options).
- Preferred Blue® PPO Options can be sold alongside any product with the Hospital Choice Cost Sharing feature (HCCS or Options). Preferred Blue PPO Options can also be sold alongside any HMO Blue New England product without the Hospital Choice Cost Sharing feature as long as Preferred Blue PPO Options is for out-of-New England employees only.
- HMO Blue New England Options Deductible II, and HMO Blue New England Options Deductible III can be sold alongside any Non-Hospital Choice Cost Sharing PPO product as long as the Non-Hospital Choice Cost Sharing PPO product is for out-of-New England employees only.
- Any HMO Blue New England product without the Hospital Choice Cost Sharing feature can be offered alongside a PPO product with the HCCS feature when the PPO is set up for out-of-New England membership only.
- HMO Blue Select can only be offered alongside other Select products, Options products, Saver products, or products with the Hospital Choice Cost Sharing feature.

FOOTNOTES

1. Value-Based Benefits:
   - Members will pay nothing for the first two diabetic monitoring visits per calendar year. These are services such as diabetes evaluation and management services, including diabetic eye exams and foot care.
   - Members will pay the same cost share for a 90-day supply of medication when purchased at the mail order pharmacy as they do for a 30-day supply when purchased from a retail pharmacy. For 4-Tier pharmacy benefits, this applies to a specific list of Tier 1, Tier 2, and Tier 3 medications used in the treatment of asthma, coronary artery disease/cardiovascular disease, and diabetes, as well as a comorbidity of depression.
   - Members will pay nothing for certain Tier 1 and Tier 2 smoking cessation products when purchased at either at a retail pharmacy or mail order pharmacy.
2. The two deductible amounts refer to per member and per family per plan year, unless otherwise noted.
3. The two out-of-pocket maximum amounts refer to per member and per family per plan year, unless otherwise noted. The out-of-pocket maximum amounts include copayments, coinsurance, and deductible, including costs for covered prescription drugs.
4. Entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.
5. The family deductible can be met through any combination of eligible costs from members on the same family plan. Each member is only responsible for their individual deductible.
6. Overall deductible does not apply to preventive or Value-Based Benefits drugs.
7. Cost sharing for these benefits may be higher when performed at a general hospital or hospital-owned outpatient facility.
8. Higher-cost hospitals are: Baystate Medical Center, Brigham and Women's Hospital, Cape Cod Hospital, Boston Children's Hospital (other than locations at Lexington, Peabody, and Waltham), Dana-Farber Cancer Institute, Fairview Hospital, Massachusetts General Hospital, and UMass Memorial Medical Center – Memorial and University Campuses.
9. Outside Massachusetts, the lower Enhanced Benefits Tier copayment applies to any network provider who is listed as a general practitioner, pediatrician, obstetrician/gynecologist, nurse practitioner, rural health center, limited services clinic, or general hospital. In New Hampshire, a Tier 1 provider equates to an Enhanced Benefits Tier provider and a Tier 2 provider equates to a Standard Benefits Tier provider.
10. To provide geographic access to members, the lower Standard Benefits Tier copayment applies to Athol Memorial Hospital, Baystate Franklin Medical Center, Berkshire Medical Center, Falmouth Hospital, Martha's Vineyard Hospital, and Nantucket Cottage Hospital.
11. Small employer group: "Eligible small business" or "group", any sole proprietorship, firm, corporation, partnership, or association actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed from one to not more than fifty full-time equivalent employees, the majority of whom worked in the commonwealth; provided, however, that a health carrier may offer health insurance to a business of more than fifty employees in accordance with the provisions of this chapter. In determining the number of full-time equivalent employees, a business shall be considered to be one eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of this chapter that apply to an eligible small business shall continue to apply through the end of the rating period in which an eligible insured no longer meets the requirements of this definition. An eligible small business that exists within a Multiple Employer Welfare Arrangement (MEWA) shall be subject to this chapter.

Questions?

If you have any questions, please contact your broker or account executive.

MASSACHUSETTS

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