MASSACHUSETTS

PRODUCT BENEFITS AND
COVERAGE OPTIONS FOR 2021

GETTING MORE. NOW THERE'S A PLAN.

51–99 HMO & PPO

Accounts with 51+ Eligible Employees and 99 or Fewer Enrolled Subscribers
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:

FULLY INSURED PLANS:

- Access Blue New England Total Saver
- HMO Blue New England Value Copayment
- Preferred Blue® PPO Value Copayment
- Blue Care® Elect Value Copayment

SELF-INSURED (ASC) PLANS:

- Access Blue New England Total Saver
- Blue Care® Elect Value Copayment
- Network Blue® New England Value Copayment

ACCESS BLUE NEW ENGLAND TOTAL SAVER

Our new "Total Saver" plan is a simple deductible-only, HSA-Qualified HDHP. The deductible amount matches the out-of-pocket amount, and once that amount is satisfied, all other covered services are available at no additional cost to the member. This plan can be paired with a HSA that can be used to pay out-of-pocket health care costs, or HSA dollars can be saved to help consumers feel more prepared for future expenses.

VALUE COPAYMENT PLANS

Our new "Value Copayment" plans allow members to more easily predict out-of-pocket costs through fixed copayments. These plans don't have a deductible, preventive care is covered at no additional cost to the member, and members are able to more easily predict out-of-pocket costs with only four levels of copayments for medical services.

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

NEW OPTIONS FOR 2021

OFFERING A LOWER COST SHARE FOR INSULIN MEDICATIONS

We know insulin medications can be expensive. We're here to help by offering a lower cost share, in an effort to reduce financial barriers and increase medication adherence for those diagnosed with diabetes.

Effective January 1, 2021, Fully Insured and Self-Funded (ASC) accounts can elect this option to apply a $25 copay for a 30-day supply of the following preferred brand insulins:

List of Preferred Medications That Are Eligible for the Lower-Cost Option	
RAPID-ACTING	Humalog®′, Humalog Junior KwikPen®′
SHORT-ACTING	Humulin®′ R, Humulin R U-500 KwikPen®′
INTERMEDIATE-ACTING	Humulin N, Humulin N KwikPen®′
LONG-ACTING	Basaglar®′, Lantus®′, Lantus SoloStar®′, Toujeo®′ SoloStar, Toujeo Max SoloStar®′
PRE-MIXED	Humalog Mix 75/25™, Humalog Mix 50/50™, Humulin 70/30, Humulin 70/30 KwikPen®′

This option is compatible with HSA Qualified plans (Saver plans), and the overall deductible will be exempt for these specific insulin medications.

COMBINED MEDICAL AND PHARMACY MAXIMUM OUT-OF-POCKET

Accounts with some non-HSA plans will have the option to allow a combined out-of-pocket maximum of $8,150/$16,300 for medical and pharmacy.

REMOVAL OF IMPACTED TEETH NO LONGER COVERED

As of January 1, 2021, upon plan renewal, we'll no longer cover the removal of impacted teeth that are fully or partially embedded in the bone, under our medical plan's outpatient surgery benefit. This is effective for all Fully Insured† and Self-Funded (ASC) Managed Care plans, as well as Insured PPO and Indemnity plans that have added this coverage under the medical plan.

This change will help us ensure consistency across our products, which will help minimize plan confusion for members, accounts, and providers.

† This excludes grandfathered accounts and Qualified Student Health Insurance Plans (QSHIP).

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, co-insurance, 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

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.[10] 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 51-99 Eligible Employees
and Enrolled Subscribers

	NEW Access Blue New England Total Saver	Access Blue New England Saver (HSA Compliant)	Access Blue New England Saver $2,000 (HSA Compliant)
DEDUCTIBLE[2]	$3,550/$7,100[5]	$1,500/$3,000[4]	$2,000/$4,000[4]
OUT-OF-POCKET MAXIMUM[3]	$3,550/$7,100	$6,450/$12,900	$6,450/$12,900
OFFICE VISIT	Preventive: $0 PCP[1]: Deductible Specialist[1]: Deductible	Preventive: $0 PCP[1]: $15 after deductible Specialist[1]: $25 after deductible	Preventive: $0 PCP[1]: $15 after deductible Specialist[1]: $25 after deductible
EMERGENCY ROOM	Deductible	$150 after deductible	$150 after deductible
INPATIENT ADMISSIONS[7]	Deductible	Deductible	Deductible
SURGICAL DAY CARE[7]	Deductible	Deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Deductible	Deductible	Deductible
PRESCRIPTION DRUGS	Retail: Deductible Mail: Deductible VBB[1]: No Cost	After deductible[6] Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135	After deductible[6] Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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

	Access Blue New England Saver $2,500 (HSA Compliant)	Access Blue New England Saver $3,000 (HSA Compliant)	Access Blue New England Basic Saver II (HSA Compliant)
DEDUCTIBLE[2]	$2,500/$5,000[4]	$3,000/$6,000[4]	$3,300/$6,450[4]
OUT-OF-POCKET MAXIMUM[3]	$6,450/$12,900	$6,450/$12,900	$6,450/$12,900
OFFICE VISIT	Preventive: $0 PCP[1]: $15 after deductible Specialist[1]: $25 after deductible	Preventive: $0 PCP[1]: $15 after deductible Specialist[1]: $25 after deductible	Preventive: $0 PCP[1]: $50 after deductible Specialist[1]: $75 after deductible
EMERGENCY ROOM	$150 after deductible	$150 after deductible	$750 after deductible
INPATIENT ADMISSIONS[7]	Deductible	Deductible	$1,000 after deductible
SURGICAL DAY CARE[7]	Deductible	Deductible	$1,000 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Deductible	Deductible	$1,000 after deductible
PRESCRIPTION DRUGS	After deductible[6] Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135	After deductible[6] Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135	After deductible[6] Retail:$ $20/$80/$100 Mail: $40/$160/$300 VBB[1]: $20/$80/$300
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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

	Access Blue New England Saver II (HSA Compliant)	NEW HMO Blue New England Value Copayment	HMO Blue New England Value Plus
DEDUCTIBLE[2]	$4,000/$8,000[5]	None	None
OUT-OF-POCKET MAXIMUM[3]	$6,850/$13,700	$8,150/$16,300	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP[1]: $25 after deductible Specialist[1]: $40 after deductible	Preventive: $0 PCP[1]: $75 Specialist[1]: $100	Preventive: $0 PCP[1]: $15 Specialist[1]: $30
EMERGENCY ROOM	Deductible	$1,000	$100
INPATIENT ADMISSIONS[7]	Deductible	$1,000	$250
SURGICAL DAY CARE[7]	Deductible	$1,000	$150
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Deductible	$1,000	$25
PRESCRIPTION DRUGS	After deductible[6] Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135	Retail: $40/$200/$250 Mail: $80/$400/$750 VBB[1]: $40/$200/$750	Retail: $10/$25/$45 Mail: $20/$50/$90 VBB[1]: $10/$25/$90
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Inpatient: $1,250 SDC: $1,150 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $475 PT/OT/ST: $65

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England Enhanced Value	HMO Blue New England Premier Value	HMO Blue New England $500 Deductible
DEDUCTIBLE[2]	None	Inpatient: $1,000/$2,500	$500/$1,000
OUT-OF-POCKET MAXIMUM[3]	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP[1]: $20 Specialist[1]: $35	Preventive: $0 PCP[1]: $25 Specialist[1]: $40	Preventive: $0 PCP[1]: $20 Specialist[1]: $35
EMERGENCY ROOM	$150	$150	$150
INPATIENT ADMISSIONS[7]	$500	Deductible	Deductible
SURGICAL DAY CARE[7]	$250	$250	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	$50	$75	Deductible
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$100 VBB[1]: $15/$30/$100	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150
HOSPITAL CHOICE COST SHARING[8]	Inpatient: $1,500 SDC: $1,250 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $500 PT/OT/ST: $70	Inpatient: $1,000 after deductible SDC: $1,250 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $525 PT/OT/ST: $75	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $70

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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 $1,000 Deductible	HMO Blue New England $1,000 Deductible with Copayment	HMO Blue New England $1,000 Deductible with Coinsurance
DEDUCTIBLE[2]	$1,000/$2,000	$1,000/$2,000	$1,000/$2,000
OUT-OF-POCKET MAXIMUM[3]	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP[1]: $20 Specialist[1]: $35	Preventive: $0 PCP[1]: $20 Specialist[1]: $35	Preventive: $0 PCP[1]: $20 Specialist[1]: $35
EMERGENCY ROOM	$150	$100 after deductible	20% coinsurance after deductible
INPATIENT ADMISSIONS[7]	Deductible	$500 after deductible	20% coinsurance after deductible
SURGICAL DAY CARE[7]	Deductible	$250 after deductible	20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Deductible	$50 after deductible	20% coinsurance after deductible
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135
HOSPITAL CHOICE COST SHARING[8]	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $70	After deductible Inpatient: $1,500 SDC: $1,250 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $500 PT/OT/ST: $70	After deductible Inpatient: 30% coinsurance SDC: 30% coinsurance Labs: 30% coinsurance X-rays: 30% coinsurance MRI/CT/PET/NC: 30% coinsurance PT/OT/ST: $75

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England $1,500 Deductible	HMO Blue New England $2,000 Deductible	HMO Blue New England $2,000 Deductible with Copayment
DEDUCTIBLE[2]	$1,500/$3,000	$2,000/$4,000	$2,000/$4,000
OUT-OF-POCKET MAXIMUM[3]	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP[1]: $20 Specialist[1]: $35	Preventive: $0 PCP[1]: $20 Specialist[1]: $35	Preventive: $0 PCP[1]: $20 Specialist[1]: $35
EMERGENCY ROOM	$150	$150	$250 after deductible
INPATIENT ADMISSIONS[7]	Deductible	Deductible	$500 after deductible
SURGICAL DAY CARE[7]	Deductible	Deductible	$250 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Deductible	Deductible	$250 after deductible
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150
HOSPITAL CHOICE COST SHARING[8]	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $70	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $70	After deductible Inpatient: $1,500 SDC: $1,250 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $700 PT/OT/ST: $70

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England Basic Copayment	HMO Blue New England $3,000 Deductible
DEDUCTIBLE[2]	$2,000/$4,000	$3,000/$6,000
OUT-OF-POCKET MAXIMUM[3]	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP[1]: $60 Specialist[1]: $75	Preventive: $0 PCP[1]: $20 Specialist[1]: $35
EMERGENCY ROOM	$750 after deductible	$150
INPATIENT ADMISSIONS[7]	$1,000 after deductible	Deductible
SURGICAL DAY CARE[7]	$1,000 after deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	$1,000 after deductible	Deductible
PRESCRIPTION DRUGS	Retail: $20/$40/$60 Mail: $40/$80/$180 VBB[1]: $20/$40/$180	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $70

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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 Deductible II	HMO Blue New England Options Deductible v.5[9]	HMO Blue New England Options Deductible II v.5[9]
DEDUCTIBLE[2]	$4,000/$8,000	EBT: None SBT: $500/$1,000 BBT: $2,000/$4,000	EBT: None SBT: $500/$1,000 BBT: $2,000/$4,000
OUT-OF-POCKET MAXIMUM[3]	Medical: $7,000/$14,000 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP[1]: $25 Specialist[1]: $40	Preventive: $0 PCP[1]: EBT: $15 SBT: $25 BBT: $50 Specialist[1]: $50	Preventive: $0 PCP[1]: EBT: $20 SBT: $30 BBT: $50 Specialist[1]: $50
EMERGENCY ROOM	$500	$150	$200
INPATIENT ADMISSIONS[7]	Deductible	EBT: $150 SBT: $150 after deductible ($200 for select hospitals)[10] BBT: $1,000 after deductible	EBT: $250 SBT: $250 after deductible ($300 for select hospitals)[10] BBT: $1,500 after deductible
SURGICAL DAY CARE[7]	Deductible	EBT: $150 SBT: $150 after deductible ($200 for select hospitals)[10] BBT: $1,000 after deductible	EBT: $250 SBT: $250 after deductible ($300 for select hospitals)[10] BBT: $1,500 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Deductible	EBT: $50 SBT: $50 after deductible ($50 for select hospitals)[10] BBT: $450 after deductible Other Network Provider: $50	EBT: $75 SBT: $75 after deductible ($75 for select hospitals)[10] BBT: $450 after deductible Other Network Provider: $75
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$35/$50 Mail: $30/$70/$150 VBB[1]: $15/$35/$150
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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 Options Deductible III v.5	HMO Blue Select $1,000 Deductible	HMO Blue Select $1,000 Deductible with Copayment
DEDUCTIBLE[2]	$2,000/$4,000	$1,000/$2,000	$1,000/$2,000
OUT-OF-POCKET MAXIMUM[3]	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP[1]: EBT: $20 SBT: $35 BBT: $55 Specialist[1]: $55	Preventive: $0 PCP[1]: $20 Specialist[1]: $35	Preventive: $0 PCP[1]: $20 Specialist[1]: $35
EMERGENCY ROOM	$250	$150	$100 after deductible
INPATIENT ADMISSIONS[7]	EBT: Deductible SBT: $500 after deductible ($50 after deductible for select hospitals)[10] BBT: $1,500 after deductible	Deductible	$500 after deductible
SURGICAL DAY CARE[7]	EBT: Deductible SBT: $500 after deductible ($50 after deductible for select hospitals)[10] BBT: $1,500 after deductible	Deductible	$250 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	EBT: Deductible SBT: $75 after deductible BBT: $450 after deductible Other Network Provider: $0	Deductible	$50 after deductible
PRESCRIPTION DRUGS	Retail: $20/$40/$60 Mail: $40/$80/$180 VBB[1]: $20/$40/$180	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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 $2,000 Deductible	HMO Blue Select $2,000 Deductible with Copayment	HMO Blue Select $3,000 Deductible
DEDUCTIBLE[2]	$2,000/$4,000	$2,000/$4,000	$3,000/$6,000
OUT-OF-POCKET MAXIMUM[3]	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP[1]: $20 Specialist[1]: $35	Preventive: $0 PCP[1]: $20 Specialist[1]: $35	Preventive: $0 PCP[1]: $20 Specialist[1]: $35
EMERGENCY ROOM	$150	$250 after deductible	$150
INPATIENT ADMISSIONS[7]	Deductible	$500 after deductible	Deductible
SURGICAL DAY CARE[7]	Deductible	$250 after deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	Deductible	$250 after deductible	Deductible
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150	Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS | BLUE SELECT

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

PPO

Accounts with 51-99 Eligible Employees and Enrolled Subscribers

	NEW Blue Care® Elect Value Copayment	Blue Care® Elect Value Plus	Blue Care® Elect Enhanced Value
DEDUCTIBLE[2]	IN: None OON: $500/$1,000	IN: None OON: $500/$1,000	IN: None OON: $500/$1,000
OUT-OF-POCKET MAXIMUM[3]	IN and OON combined: $8,150/$16,300	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $75 Specialist[1]: $100 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $15 Specialist[1]: $15 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $20 Specialist[1]: $20 OON: 20% coinsurance after deductible
EMERGENCY ROOM	$1,000	$100	$150
INPATIENT ADMISSIONS[7]	IN: $1,000 OON: 20% coinsurance after deductible	IN: $250 OON: 20% coinsurance after deductible	IN: $500 OON: 20% coinsurance after deductible
SURGICAL DAY CARE[7]	IN: $1,000 OON: 20% coinsurance after deductible	IN: $150 OON: 20% coinsurance after deductible	IN: $250 OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: $1,000 OON: 20% coinsurance after deductible	IN: $25 OON: 20% coinsurance after deductible	IN: $50 OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $40/$200/$250 Mail: $80/$400/$750 VBB[1]: $40/$200/$750 OON: Not covered	IN: Retail: $10/$25/$45 Mail: $20/$50/$90 VBB[1]: $10/$25/$90 OON: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$100 VBB[1]: $15/$30/$100 OON: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Inpatient: $1,250 SDC: $1,150 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $475 PT/OT/ST: $50	Inpatient: $1,500 SDC: $1,250 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $500 PT/OT/ST: $55

LEGEND: HOSPITAL CHOICE COST SHARING BLUE OPTIONS

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

	Blue Care® Elect $3,000 Deductible	Blue Care® Elect $4,500 Deductible	NEW Preferred Blue® PPO Value Copayment
DEDUCTIBLE[2]	IN and OON combined: $3,000/$7,500	IN and OON combined: $4,500/$9,000	IN: None OON: $500/$1,000
OUT-OF-POCKET MAXIMUM[3]	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN and OON combined: $8,150/$16,300
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $15 after deductible Specialist[1]: $15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $25 after deductible Specialist[1]: $25 after deductible OON: $45 after deductible	IN: Preventive: $0 Primary Care[1]: $75 Specialist[1]: $100 OON: 20% coinsurance after deductible
EMERGENCY ROOM	$150 after deductible	$150 after deductible	$1,000
INPATIENT ADMISSIONS[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: $1,000 OON: 20% coinsurance after deductible
SURGICAL DAY CARE[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: $1,000 OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: $1,000 OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150 OON: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150 OON: Not covered	IN: Retail: $40/$200/$250 Mail: $80/$400/$750 VBB[1]: $140/$200/$750 OON: Retail: $80/$400/$500 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $50	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS

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 Basic Copayment	Preferred Blue® PPO 80 with Copayment	Preferred Blue® PPO $500 Deductible
DEDUCTIBLE[2]	IN: $2,000/$4,000 OON: $4,000/$8,000	IN and OON combined: $500/$1,000	IN and OON combined: $500/$1,000
OUT-OF-POCKET MAXIMUM[3]	IN: Medical: $5,450/$10,900 Rx: $1,000/$2,000 OON: Medical: $10,900/$21,800 Rx: $2,000/$4,000	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $65 Specialist[1]: $65 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $20 Specialist[1]: $20 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $15 after deductible Specialist[1]: $15 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$750 after in-network deductible	$150	$150 after deductible
INPATIENT ADMISSIONS[7]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[7]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: $250 after deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $20/$40/$60 Mail: $40/$80/$180 VBB[1]: $20/$40/$180 OON: Retail: $40/$80/$120 Mail: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150 OON: Retail: $30/$60/$100 Mail: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150 OON: Retail: $30/$60/$100 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $50

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS

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 $1,000 Deductible	Preferred Blue® PPO $2,000 Deductible	Preferred Blue® PPO Deductible II
DEDUCTIBLE[2]	IN and OON combined: $1,000/$2,500	IN and OON combined: $2,000/$4,000	IN and OON combined: $4,000/$8,000
OUT-OF-POCKET MAXIMUM[3]	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN and OON combined: Medical: $7,000/$14,000 Rx: $1,000/$2,000
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $15 after deductible Specialist[1]: $15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $15 after deductible Specialist[1]: $15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $25 after deductible Specialist[1]: $40 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$150 after deductible	$150 after deductible	Deductible
INPATIENT ADMISSIONS[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150 OON: Retail: $30/$60/$100 Mail: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150 OON: Retail: $30/$60/$100 Mail: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150 OON: Retail $30/$60/$100 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $50	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $50	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS

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 Options v.5[9]	Preferred Blue® PPO Options Deductible II v.5[9]	Preferred Blue® PPO Options Deductible III v.5[9]
DEDUCTIBLE[2]	IN: None OON: $2,000/$4,000	IN: EBT: None SBT: $500/$1,000 BBT: $2,000/$4,000 OON: $4,000/$8,000	IN: $2,000/$4,000 OON: $4,000/$8,000
OUT-OF-POCKET MAXIMUM[3]	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN: Medical: $4,850/$9,700 Rx: $2,000/$4,000 OON: Medical: $7,500/$15,000 Rx: $2,000/$4,000	IN: Medical: $5,850/$11,700 Rx: $1,000/$2,000 OON: Medical: $7,500/$15,000 Rx: $2,000/$4,000
OFFICE VISIT	IN: Preventive: $0 EBT[1]: $15 SBT[1]: $25 BBT[1]: $45 Other Network Provider[1]: $45 OON: 20% coinsurance after deductible	IN: Preventive: $0 EBT[1]: $20 SBT[1]: $35 BBT[1]: $55 Other Network Provider[1]: $55 OON: 20% coinsurance after deductible	IN: Preventive: $0 EBT[1]: $20 SBT[1]: $35 BBT[1]: $55 Other Network Provider[1]: $55 OON: 20% coinsurance after deductible
EMERGENCY ROOM	$150	$250	$250
INPATIENT ADMISSIONS[7]	IN: EBT: $250 SBT: $500 ($300 for select hospitals)[10] BBT: $1,000 OON: 20% coinsurance after deductible	IN: EBT: $500 SBT: $500 after deductible ($550 for select hospitals)[10] BBT: $1,500 after deductible OON: 20% coinsurance after deductible	IN: EBT: Deductible SBT: $500 after deductible ($50 after deductible for select hospitals)[10] BBT: $1,500 after deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[7]	IN: EBT: $150 SBT: $250 BBT: $500 OON: 20% coinsurance after deductible	IN: EBT: $500 SBT: $500 after deductible ($550 for select hospitals)[10] BBT: $1,500 after deductible OON: 20% coinsurance after deductible	IN: EBT: Deductible SBT: $500 after deductible ($50 after deductible for select hospitals)[10] BBT: $1,500 after deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: EBT: $75 SBT: $150 BBT: $250 Other Network Provider: $75 OON: 20% coinsurance after deductible	IN: EBT: $75 SBT: $75 after deductible ($75 for select hospitals)[10] BBT: $450 after deductible Other Network Provider: $75 OON: 20% coinsurance after deductible	IN: EBT: Deductible SBT: $75 after deductible BBT: $450 after deductible Other Network Provider: $0 OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 VBB[1]: $15/$30/$150 OON: Retail: $30/$60/$100 Mail: Not covered	IN: Retail: $20/$40/$60/$120 Mail: $40/$80/$120/$360 VBB[1]: $20/$40/$60/$360 OON: Retail: $40/$80/$120/$240 Mail: Not covered	IN: Retail: $15/$30/$60/$120 Mail: $30/$60/$120/$360 VBB[1]: $15/$30/$60/$360 OON: Retail: $30/$60/$120/$240 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS

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 $1,500 (HSA Compliant)	Preferred Blue® PPO Saver $2,000 (HSA Compliant)	Preferred Blue® PPO Saver $2,900 (HSA Compliant)
DEDUCTIBLE[2]	IN and OON combined: $1,500/$3,000[4]	IN and OON combined: $2,000/$4,000[4]	IN and OON combined: $2,900/$5,800[4]
OUT-OF-POCKET MAXIMUM[3]	IN and OON combined: $6,450/$12,900	IN and OON combined: $6,450/$12,900	IN and OON combined: $6,450/$12,900
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: Deductible Specialist[1]: Deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: Deductible Specialist[1]: Deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: Deductible Specialist[1]: Deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$150 after deductible	$150 after deductible	$150 after deductible
INPATIENT ADMISSIONS[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	After deductible[6] IN: Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135 (no deductible) OON: Retail: $20/$50/$90 Mail: Not covered	After deductible[6] IN: Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135 (no deductible) OON: Retail: $20/$50/$90 Mail: Not covered	After deductible[6] IN: Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135 (no deductible) OON: Retail: $20/$50/$90 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS

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 Basic Saver (HSA Compliant)	Preferred Blue® PPO Saver II (HSA Compliant)
DEDUCTIBLE[2]	IN: $3,300/$6,450[4] OON: $6,300/$10,000[4]	IN and OON combined: $4,000/$8,000[5]
OUT-OF-POCKET MAXIMUM[3]	IN: $6,450/$12,900 OON: $11,000/$23,000	IN and OON combined: $6,850/$13,700
OFFICE VISIT	IN: Preventive: $0 Primary Care[1]: $60 after deductible Specialist[1]: $60 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care[1]: $25 after deductible Specialist[1]: $40 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$750 after in-network deductible	Deductible
INPATIENT ADMISSIONS[7]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[7]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[7]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	After deductible[6] IN: Retail: $20/$80/$100 Mail: $40/$160/$300 VBB[1]: $20/$80/$300 (no deductible) OON: Retail: $40/$160/$200 Mail: Not covered	After deductible[6] IN: Retail: $10/$25/$45 Mail: $20/$50/$135 VBB[1]: $10/$25/$135 (no deductible) OON: Retail: $20/$50/$90 Mail: Not covered
HOSPITAL CHOICE COST SHARING[8]	Not Applicable	Not Applicable

LEGEND: HOSPITAL CHOICE COST SHARING BLUE OPTIONS

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 Access Blue New England Basic Saver II and Preferred Blue PPO Basic Saver. Creditable Coverage means that the member's prescription drug coverage is as good as or better than the standard Medicare Part D plan.

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 all plans in this chart.

MINIMUM CREDITABLE COVERAGE

All plans in this chart meet the minimum level of benefits for adult tax filers 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.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS ALLOWS EMPLOYER GROUPS WITH 51+ ELIGIBLE EMPLOYEES WITH 99 OR FEWER ENROLLED TO PROVIDE MULTIPLE PLAN OPTIONS TO THEIR EMPLOYEES.

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).
- HMO Blue New England Options Deductible, 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.
- 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 a retail pharmacy or mail 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 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.

Questions?

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

MASSACHUSETTS

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