MASSACHUSETTS

PRODUCT BENEFITS AND
COVERAGE OPTIONS FOR 2021

GETTING MORE.
NOW THERE'S A PLAN.

100+ HMO & PPO

Accounts with 100+ Eligible Employees and 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 75/25TM, Humalog Mix 50/50TM, 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.

$0 COPAY MEDICATIONS

Accounts will be able to include an option that offers certain medications within the categories listed below at $0 copay or coinsurance. Accounts can select which categories of medications to include with this option. Accounts can choose to pair this option with the HSA preventive medication list, so the overall deductible will be exempt for certain medications in the categories below.

CONDITIONS:

- Blood Pressure and Heart Conditions
- High Cholesterol
- Depression
- Diabetes
- Respiratory Conditions

Offering $0 copays for certain medications helps reduce financial barriers and improve medication adherence for our members.

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† or 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). ASC accounts can add coverage back into a medical plan, or maintain their current coverage.

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

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 100+ Eligible Employees
and Enrolled Subscribers

	NEW Access Blue New England Total Saver	Access Blue New England Enhanced Value	Access Blue New England Basic $2,000
DEDUCTIBLE[1]	$3,550/$7,100[4]	None	Medical: $2,000/$4,000 Rx: $250/$500
OUT-OF-POCKET MAXIMUM[2]	$3,550/$7,100	Medical: $5,450/$10,900 Rx: $1,000/$2,000	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Deductible	Preventive: $0 PCP: $20 Specialist: $30	Preventive: $0 PCP: $25 after deductible Specialist: $35 after deductible
EMERGENCY ROOM	Deductible	$150	$200
INPATIENT ADMISSIONS[5]	Deductible	$500	20% coinsurance after deductible
SURGICAL DAY CARE[5]	Deductible	$250	20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	Deductible	$50	20% coinsurance after deductible
PRESCRIPTION DRUGS	Deductible	Retail: $15/$30/$50 Mail: $30/$60/$100	Tier 1: Retail: $15/Mail: $30 Tiers 2 and 3: Retail and Mail: 50% coinsurance after Rx deductible
HOSPITAL CHOICE COST SHARING[6]	Not Applicable	Inpatient: $1,500 SDC: $1,250 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $500 PT/OT/ST: $65	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

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 (HSA Compliant)	Access Blue New England Basic Saver (HSA Compliant)	Access Blue New England Basic Saver II (HSA Compliant)
DEDUCTIBLE[1]	$1,500/$3,000[3]	$3,000/$5,950[3]	$3,300/$6,450[3]
OUT-OF-POCKET MAXIMUM[2]	$6,450/$12,900	$6,450/$12,900	$6,450/$12,900
OFFICE VISIT	Preventive: $0 PCP: $15 after deductible Specialist: $25 after deductible	Preventive: $0 PCP: $60 after deductible Specialist: $75 after deductible	Preventive: $0 PCP: $50 after deductible Specialist: $75 after deductible
EMERGENCY ROOM	$150 after deductible	$250 after deductible	$750 after deductible
INPATIENT ADMISSIONS[5]	Deductible	35% coinsurance after deductible	$1,000 after deductible
SURGICAL DAY CARE[5]	Deductible	35% coinsurance after deductible	$1,000 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	Deductible	35% coinsurance after deductible	$1,000 after deductible
PRESCRIPTION DRUGS	After deductible Retail: $10/$25/$45 Mail: $20/$50/$135	After deductible Retail: $15/$30/$50 Mail: $30/$60/$150	After deductible Tier 1: Retail: $15/Mail: $30 Tiers 2 and 3: Retail and Mail: 50% coinsurance
HOSPITAL CHOICE COST SHARING[6]	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

	Blue Choice® New England	Blue Choice® New England Value Plus	Blue Choice® New England Deductible
DEDUCTIBLE[1]	PCP/Plan-Approved: None Self-Referred: $250/$500 per calendar year	PCP/Plan-Approved: None Self-Referred: $500/$1,000 per calendar year	PCP/Plan-Approved: $1,000/$2,000 per calendar year Self-Referred: $2,000/$4,000 per calendar year
OUT-OF-POCKET MAXIMUM[2]	PCP/Plan-Approved: Medical: $5,450/$10,900 per calendar year Rx: $1,000/$2,000 per calendar year Self-Referred: Medical: $6,450/$12,900 per calendar year	PCP/Plan-Approved: Medical: $5,450/$10,900 per calendar year Rx: $1,000/$2,000 per calendar year Self-Referred: Medical: $6,450/$12,900 per calendar year	PCP/Plan-Approved: Medical: $5,450/$10,900 per calendar year Rx: $1,000/$2,000 per calendar year Self-Referred: Medical: $6,450/$12,900 per calendar year
OFFICE VISIT	PCP/Plan-Approved: Preventive: $0 PCP: $10 Specialist: $10 Self-Referred: 20% coinsurance after deductible	PCP/Plan-Approved: Preventive: $0 PCP: $15 Specialist: $15 Self-Referred: 20% coinsurance after deductible	PCP/Plan-Approved: Preventive: $0 PCP: $20 Specialist: $35 Self-Referred: 20% coinsurance after deductible
EMERGENCY ROOM	$100	$100	$150
INPATIENT ADMISSIONS[5]	PCP/Plan-Approved: $0 Self-Referred: 20% coinsurance after deductible	PCP/Plan-Approved: $250 Self-Referred: 20% coinsurance after deductible	PCP/Plan-Approved: Deductible Self-Referred: 20% coinsurance after deductible
SURGICAL DAY CARE[5]	PCP/Plan-Approved: $0 Self-Referred: 20% coinsurance after deductible	PCP/Plan-Approved: $150 Self-Referred: 20% coinsurance after deductible	PCP/Plan-Approved: Deductible Self-Referred: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	PCP/Plan-Approved: $25 Self-Referred: 20% coinsurance after deductible	PCP/Plan-Approved: $25 Self-Referred: 20% coinsurance after deductible	PCP/Plan-Approved: Deductible Self-Referred: 20% coinsurance after deductible
PRESCRIPTION DRUGS	PCP/Plan-Approved: Retail: $10/$25/$45 Mail: $20/$50/$90 Self-Referred: Not covered	PCP/Plan-Approved: Retail: $10/$25/$45 Mail: $20/$50/$90 Self-Referred: Not covered	PCP/Plan-Approved: Retail: $15/$30/$50 Mail: $30/$60/$150 Self-Referred: Not covered
HOSPITAL CHOICE COST SHARING[6]	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

	NEW HMO Blue New England Value Copayment	HMO Blue New England	HMO Blue New England $500 Deductible
DEDUCTIBLE[1]	None	None	$500/$1,000
OUT-OF-POCKET MAXIMUM[2]	$8,150/$16,300	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: $75 Specialist: $100	Preventive: $0 PCP: $10 Specialist: $25	Preventive: $0 PCP: $20 Specialist: $35
EMERGENCY ROOM	$1,000	$100	$150
INPATIENT ADMISSIONS[5]	$1,000	$0	Deductible
SURGICAL DAY CARE[5]	$1,000	$0	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	$1,000	$25	Deductible
PRESCRIPTION DRUGS	Retail: $40/$200/$250 Mail: $80/$400/$750	Retail: $10/$25/$45 Mail: $20/$50/$90	Retail: $15/$30/$50 Mail: $30/$60/$150
HOSPITAL CHOICE COST SHARING[6]	Inpatient: $2,000 SDC: $2,000 Labs: $135 X-rays: $350 MRI/CT/PET/NC: $1,450 PT/OT/ST: $135	Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $475 PT/OT/ST: $60	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

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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 Coinsurance	HMO Blue New England $1,500 Deductible
DEDUCTIBLE[1]	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000
OUT-OF-POCKET MAXIMUM[2]	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: $20 Specialist: $35	Preventive: $0 PCP: $20 Specialist: $35	Preventive: $0 PCP: $20 Specialist: $35
EMERGENCY ROOM	$150	20% coinsurance after deductible	$150
INPATIENT ADMISSIONS[5]	Deductible	20% coinsurance after deductible	Deductible
SURGICAL DAY CARE[5]	Deductible	20% coinsurance after deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	Deductible	Deductible	Deductible
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $10/$25/$45 Mail: $20/$50/$135	Retail: $15/$30/$50 Mail: $30/$60/$150
HOSPITAL CHOICE COST SHARING[6]	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: 30% coinsurance SDC: 30% coinsurance Labs: 30% coinsurance X-rays: 30% coinsurance MRI/CT/PET/NC: 30% coinsurance 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

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	HMO Blue New England $2,000 Deductible	HMO Blue New England $3,000 Deductible
DEDUCTIBLE[1]	$2,000/$4,000	$3,000/$6,000
OUT-OF-POCKET MAXIMUM[2]	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: $20 Specialist: $35	Preventive: $0 PCP: $25 Specialist: $40
EMERGENCY ROOM	$150	$150
INPATIENT ADMISSIONS[5]	Deductible	Deductible
SURGICAL DAY CARE[5]	Deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	Deductible	Deductible
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150
HOSPITAL CHOICE COST SHARING[6]	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: $75

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

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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England Deductible II	HMO Blue New England Basic Copayment	HMO Blue New England Basic Coinsurance
DEDUCTIBLE[1]	$4,000/$8,000	$2,000/$4,000	$2,000/$4,000
OUT-OF-POCKET MAXIMUM[2]	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: $25 Specialist: $40	Preventive: $0 PCP: $60 Specialist: $75	Preventive: $0 PCP: $60 Specialist: $75
EMERGENCY ROOM	$500	$750 after deductible	35% coinsurance after deductible
INPATIENT ADMISSIONS[5]	Deductible	$1,000 after deductible	35% coinsurance after deductible
SURGICAL DAY CARE[5]	Deductible	$1,000 after deductible	35% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	Deductible	$1,000 after deductible	35% coinsurance after deductible
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $20/$40/$60 Mail: $40/$80/$180	Tier 1: Retail: $15/Mail: $30 Tiers 2 & 3: Retail & Mail: 50% coinsurance
HOSPITAL CHOICE COST SHARING[6]	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $450 PT/OT/ST: $75	Not Applicable	Not Applicable

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

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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England Options v.5[7]	HMO Blue New England Options Deductible v.5[7]	HMO Blue New England Options Deductible II v.5[7]
DEDUCTIBLE[1]	None	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[2]	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: EBT: $15 SBT: $25 BBT: $45 Specialist: $45	Preventive: $0 PCP: EBT: $15 SBT: $25 BBT: $50 Specialist: $50	Preventive: $0 PCP: EBT: $20 SBT: $30 BBT: $50 Specialist: $50
EMERGENCY ROOM	$150	$150	$200
INPATIENT ADMISSIONS[5]	EBT: $250 SBT: $500 ($300 for select hospitals)[8] BBT: $1,000	EBT: $150 SBT: $150 after deductible ($200 for select hospitals)[8] BBT: $1,000 after deductible	EBT: $250 SBT: $250 after deductible ($300 for select hospitals)[8] BBT: $1,500 after deductible
SURGICAL DAY CARE[5]	EBT: $150 SBT: $250 BBT: $500	EBT: $150 SBT: $150 after deductible ($200 for select hospitals)[8] BBT: $1,000 after deductible	EBT: $250 SBT: $250 after deductible ($300 for select hospitals)[8] BBT: $1,500 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	EBT: $75 SBT: $150 BBT: $250 Other Network Provider: $75	EBT: $50 SBT: $50 after deductible ($50 for select hospitals)[8] BBT: $450 after deductible Other Network Provider: $50	EBT: $75 SBT: $75 after deductible ($75 for select hospitals)[8] BBT: $450 after deductible Other Network Provider: $75
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$35/$50 Mail: $30/$70/$150
HOSPITAL CHOICE COST SHARING[6]	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[7]	HMO Blue New England Value	HMO Blue New England Value Plus
DEDUCTIBLE[1]	$2,000/$4,000	None	None
OUT-OF-POCKET MAXIMUM[2]	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: EBT: $20 SBT: $35 BBT: $55 Specialist: $55	Preventive: $0 PCP: $25 Specialist: $40	Preventive: $0 PCP: $15 Specialist: $30
EMERGENCY ROOM	$250	$150	$100
INPATIENT ADMISSIONS[5]	EBT: Deductible SBT: $500 after deductible ($50 after deductible for select hospitals)[8] BBT: $1,500 after deductible	$500	$250
SURGICAL DAY CARE[5]	EBT: Deductible SBT: $500 after deductible ($50 after deductible for select hospitals)[8] BBT: $1,500 after deductible	$250	$150
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	EBT: Deductible SBT: $75 after deductible BBT: $450 after deductible Other Network Provider: $0	$75	$25
PRESCRIPTION DRUGS	Retail: $20/$40/$60 Mail: $40/$80/$180	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $10/$25/$45 Mail: $20/$50/$90
HOSPITAL CHOICE COST SHARING[6]	Not Applicable	Inpatient: $1,500 SDC: $1,250 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $525 PT/OT/ST: $75	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

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 Enhanced Value	HMO Blue New England Premier Value	HMO Blue New England Premier Value with Coinsurance
DEDUCTIBLE[1]	None	Inpatient: $1,000/$2,500	Inpatient: $1,000/$2,500
OUT-OF-POCKET MAXIMUM[2]	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: $20 Specialist: $35	Preventive: $0 PCP: $25 Specialist: $40	Preventive: $0 PCP: $25 Specialist: $40
EMERGENCY ROOM	$150	$150	$200
INPATIENT ADMISSIONS[5]	$500	Deductible	Deductible
SURGICAL DAY CARE[5]	$250	$250	35% coinsurance
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	$50	$75	35% coinsurance
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$100	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150
HOSPITAL CHOICE COST SHARING[6]	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	Inpatient: $1,000 after deductible SDC: 50% coinsurance Labs: 50% coinsurance X-rays: 50% coinsurance MRI/CT/PET/NC: 50% coinsurance PT/OT/ST: $75

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

	HMO Blue Select Deductible
DEDUCTIBLE[1]	$1,000/$2,000
OUT-OF-POCKET MAXIMUM[2]	Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	Preventive: $0 PCP: $20 Specialist: $35
EMERGENCY ROOM	$150
INPATIENT ADMISSIONS[5]	Deductible
SURGICAL DAY CARE[5]	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	Deductible
PRESCRIPTION DRUGS	Retail: $15/$30/$50 Mail: $30/$60/$150
HOSPITAL CHOICE COST SHARING[6]	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 100+ Eligible Employees
and Enrolled Subscribers

	NEW Blue Care® Elect Value Copayment	Blue Care® Elect Preferred	Blue Care® Elect Preferred 90 with Copayment
DEDUCTIBLE[1]	IN: None OON: $500/$1,000	IN: None OON: $250/$500	IN and OON combined: $250/$500
OUT-OF-POCKET MAXIMUM[2]	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: $75 Specialist: $100 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $15 Specialist: $15 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $15 Specialist: $15 OON: 20% coinsurance after deductible
EMERGENCY ROOM	$1,000	$100	$150
INPATIENT ADMISSIONS[5]	IN: $1,000 OON: 20% coinsurance after deductible	IN: $0 OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible
SURGICAL DAY CARE[5]	IN: $1,000 OON: 20% coinsurance after deductible	IN: $0 OON: 20% coinsurance after deductible	IN: $250 after deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	IN: $1,000 OON: 20% coinsurance after deductible	IN: $25 OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $40/$200/$250 Mail: $80/$400/$750 OON: Not covered	IN: Retail: $10/$25/$45 Mail: $20/$50/$90 OON: Not covered	IN: Retail: $10/$25/$45 Mail: $20/$50/$90 OON: Not covered
HOSPITAL CHOICE COST SHARING[6]	Inpatient: $2,000 SDC: $2,000 Labs: $135 X-rays: $350 MRI/CT/PET/NC: $1,450 PT/OT/ST: $135	Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/NC: $475 PT/OT/ST: $50	After deductible Inpatient: 20% coinsurance SDC: $1,250 Labs: 20% coinsurance X-rays: 20% coinsurance MRI/CT/PET/NC: 20% coinsurance PT/OT/ST: $50 (no deductible)

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 Preferred 90	Blue Care® Elect Preferred 80 wih Copayment	Blue Care® Elect Preferred 80
DEDUCTIBLE[1]	IN and OON combined: $250/$500	IN and OON combined: $500/$1,000	IN and OON combined: $500/$1,000
OUT-OF-POCKET MAXIMUM[2]	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: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	IN: Preventive: $0 Primary Care: 10% coinsurance after deductible Specialist: 10% coinsurance after deductible OON: 30% coinsurance after deductible	IN: Preventive: $0 Primary Care: $20 Specialist: $20 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: 20% coinsurance after deductible Specialist: 20% coinsurance after deductible OON: 40% coinsurance after deductible
EMERGENCY ROOM	10% coinsurance after deductible	$150	20% coinsurance after deductible
INPATIENT ADMISSIONS[5]	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible
SURGICAL DAY CARE[5]	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible	IN: $250 after deductible OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $10/$25/$45 Mail: $20/$50/$90 OON: Not covered	IN: Retail: $10/$25/$45 Mail: $20/$50/$90 OON: Not covered	IN: Retail: $10/$25/$45 Mail: $20/$50/$90 OON: Not covered
HOSPITAL CHOICE COST SHARING[6]	After deductible Inpatient: 20% coinsurance SDC: 20% coinsurance Labs: 20% coinsurance X-rays: 20% coinsurance MRI/CT/PET/NC: 20% coinsurance PT/OT/ST: 20% coinsurance	After deductible Inpatient: 30% coinsurance SDC: $1,250 Labs: 30% coinsurance X-rays: 30% coinsurance MRI/CT/PET/NC: 30% coinsurance PT/OT/ST: $55 (no deductible)	After deductible Inpatient: 30% coinsurance SDC: 30% coinsurance Labs: 30% coinsurance X-rays: 30% coinsurance MRI/CT/PET/NC: 30% coinsurance PT/OT/ST: 30% coinsurance

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 Value Plus	Blue Care Elect Enhanced Value	Blue Care Elect $1,000 Deductible
DEDUCTIBLE[1]	IN: None OON: $500/$1,000	IN: None OON: $500/$1,000	IN and OON combined: $1,000/$2,500
OUT-OF-POCKET MAXIMUM[2]	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: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	IN: Preventive: $0 Primary Care: $15 Specialist: $15 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $20 Specialist: $20 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $15 after deductible Specialist: $15 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$100	$150	$150 after deductible
INPATIENT ADMISSIONS[5]	IN: $250 OON: 20% coinsurance after deductible	IN: $500 OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[5]	IN: $150 OON: 20% coinsurance after deductible	IN: $250 OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	IN: $25 OON: 20% coinsurance after deductible	IN: $50 OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $10/$25/$45 Mail: $20/$50/$90 OON: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$100 OON: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 OON: Not covered
HOSPITAL CHOICE COST SHARING[6]	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	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
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FOOTNOTES LOCATED ON THE LAST PAGE

	Blue Care Elect $1,500 Deductible	Blue Care Elect $2,000 Deductible	Blue Care Elect $3,000 Deductible
DEDUCTIBLE[1]	IN and OON combined: $1,500/$3,750	IN and OON combined: $2,000/$4,000	IN and OON combined: $3,000/$7,500
OUT-OF-POCKET MAXIMUM[2]	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: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	IN: Preventive: $0 Primary Care: $15 after deductible Specialist: $15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $15 after deductible Specialist: $15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $15 after deductible Specialist: $15 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$150 after deductible	$150 after deductible	$150 after deductible
INPATIENT ADMISSIONS[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[5]	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[5]	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 OON: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 OON: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 OON: Not covered
HOSPITAL CHOICE COST SHARING[6]	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	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
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FOOTNOTES LOCATED ON THE LAST PAGE

	Blue Care Elect $4,500	Blue Care Elect Saver $1,500 (HSA Compliant)	Blue Care Elect Saver 90 (HSA Compliant)
DEDUCTIBLE[1]	IN and OON combined: $4,500/$9,000	IN and OON combined: $1,500/$3,000[3]	In and OON combined: $1,500/$3,000[3]
OUT-OF-POCKET MAXIMUM[2]	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN and OON combined: $6,450/$12,900	IN and OON combined: $6,450/$12,900
OFFICE VISIT	IN: Preventive: $0 Primary Care: $25 after deductible Specialist: $25 after deductible OON: $45 after deductible	IN: Preventive: $0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 Primary Care: 10% coinsurance after deductible Specialist: 10% coinsurance after deductible OON: 30% coinsurance after deductible (20% coinsurance for preventive care)
EMERGENCY ROOM	$150 after deductible	$150 after deductible	$150 after deductible
INPATIENT ADMISSIONS[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible
SURGICAL DAY CARE[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 OON: Not covered	After deductible IN: Retail: $10/$25/$45 Mail: $20/$50/$135 OON: Retail: $20/$50/$90 Mail: Not covered	After deductible IN: Retail: $10/$25/$45 Mail: $20/$50/$135 OON: Retail: $20/$50/$90 Mail: Not covered
HOSPITAL CHOICE COST SHARING[6]	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

	Blue Care Elect Saver $2,700 (HSA Compliant)	NEW Preferred Blue® PPO Value Copayment	Preferred Blue PPO 80 with Copayment
DEDUCTIBLE[1]	IN and OON combined: $2,700/$5,400[3]	IN: None OON: $500/$1,000	IN and OON combined: $500/$1,000
OUT-OF-POCKET MAXIMUM[2]	IN and OON combined: $6,450/$12,900	IN and OON combined: $8,150/$16,300	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	IN: Preventive: $0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 Primary Care: $75 Specialist: $100 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $20 Specialist: $20 OON: 20% coinsurance after deductible
EMERGENCY ROOM	$150 after deductible	$1,000	$150
INPATIENT ADMISSIONS[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: $1,000 OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible
SURGICAL DAY CARE[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: $1,000 OON: 20% coinsurance after deductible	IN: $250 after deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: $1000 OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible
PRESCRIPTION DRUGS	After deductible IN: Retail: $10/$25/$45 Mail: $20/$50/$135 OON: Retail: $20/$50/$90 Mail: Not covered	IN: Retail: $40/$200/$250 Mail: $80/$400/$750 OON: Retail: $80/$400/$500 Mail: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 OON: Retail: $30/$60/$100 Mail: Not covered
HOSPITAL CHOICE COST SHARING[6]	Not Applicable	Inpatient: $2,000 SDC: $2,000 Labs: $135 X-rays: $350 MRI/CT/PET/NC: $1,450 PT/OT/ST: $135	After deductible Inpatient: 30% coinsurance SDC: $1,250 Labs: 30% coinsurance X-rays: 30% coinsurance MRI/CT/PET/NC: 30% coinsurance PT/OT/ST: $55, (no deductible)

LEGEND: HOSPITAL CHOICE COST SHARING | BLUE OPTIONS

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

	Preferred Blue PPO $1,000 Deductible	Preferred Blue PPO $2,000 Deductible	Preferred Blue PPO Deductible II
DEDUCTIBLE[1]	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[2]	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: $15 after deductible Specialist: $15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $15 after deductible Specialist: $15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $25 after deductible Specialist: $40 after deductible OON: 20% coinsurance after deductible
EMERGENCY ROOM	$150 after deductible	$150 after deductible	Deductible
INPATIENT ADMISSIONS[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[5]	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[5]	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 OON: Retail: $30/$60/$100 Mail: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 OON: Retail: $30/$60/$100 Mail: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 OON: Retail: $30/$60/$100 Mail: Not covered
HOSPITAL CHOICE COST SHARING[6]	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 MRI/CT/PET/NC: $450 Labs: $35 X-rays: $100 PT/OT/ST: $50	After deductible Inpatient: $1,000 SDC: $1,000 Labs: $35 X-rays: $100 MRI/CT/PET/INC: $450 PT/OT/ST: $75

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 $2,000	Preferred Blue PPO Basic Copayment	Preferred Blue PPO Basic Coinsurance
DEDUCTIBLE[1]	IN and OON combined: Medical: $2,000/$4,000 Rx: $250/$500	IN: $2,000/$4,000 OON: $4,000/$8,000	IN: $2,000/$4,000 OON: $4,000/$8,000
OUT-OF-POCKET MAXIMUM[2]	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000	IN: Medical: $5,450/$10,900 Rx: $1,000/$2,000 OON: Medical: $10,900/$21,800 Rx: $2,000/$4,000	IN: Medical: $5,450/$10,900 Rx: $1,000/$2,000 OON: Medical: $10,900/$21,800 Rx: $2,000/$4,000
OFFICE VISIT	IN: Preventive: $0 Primary Care: $25 Specialist: $25 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $65 Specialist: $65 OON: 20% coinsurance after deductible	IN: Preventive: $0 Primary Care: $60 Specialist: $60 OON: 20% coinsurance after deductible
EMERGENCY ROOM	$250	$750 after in-network deductible	35% coinsurance after in-network deductible
INPATIENT ADMISSIONS[5]	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: 35% coinsurance after deductible OON: 55% coinsurance after deductible
SURGICAL DAY CARE[5]	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: 35% coinsurance after deductible OON: 55% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: 35% coinsurance after deductible OON: 55% coinsurance after deductible
PRESCRIPTION DRUGS	IN: Retail: $15/50% coinsurance/50% coinsurance Mail: $30/50% coinsurance/50% coinsurance OON: $30/50% coinsurance/50% coinsurance Mail: Not covered	IN: Retail: $15/50% coinsurance/50% coinsurance Mail: $30/50% coinsurance/50% coinsurance OON: $30/50% coinsurance/50% coinsurance Mail: Not covered	IN: Retail: $15/50% coinsurance/50% coinsurance Mail: $30/50% coinsurance/50% coinsurance OON: $30/50% coinsurance/50% coinsurance Mail: Not covered
HOSPITAL CHOICE COST SHARING[6]	After deductible Inpatient: 30% coinsurance SDC: 30% coinsurance Labs: 30% coinsurance X-rays: 30% coinsurance MRI/CT/PET/NC: 30% coinsurance PT/OT/ST: $60, no deductible	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[1]	IN and OON combined: $1,500/$3,000[3]	IN and OON combined: $2,000/$4,000[3]	IN and OON combined: $2,900/$5,800[3]
OUT-OF-POCKET MAXIMUM[2]	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: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)
EMERGENCY ROOM	$150 after deductible	$150 after deductible	$150 after deductible
INPATIENT ADMISSIONS[5]	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[5]	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[5]	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 IN: Retail: $10/$25/$45 Mail: $20/$50/$135 OON: Retail: $20/$50/$90 Mail: Not covered	After deductible IN: Retail: $10/$25/$45 Mail: $20/$50/$135 OON: Retail: $20/$50/$90 Mail: Not covered	After deductible IN: Retail: $10/$25/$45 Mail: $20/$50/$135 OON: Retail: $20/$50/$90 Mail: Not covered
HOSPITAL CHOICE COST SHARING[6]	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)	Preferred Blue PPO Options v.5[7]
DEDUCTIBLE[1]	IN: $3,300/$6,450[3] OON: $6,300/$10,000	IN and OON combined: $4,000/$8,000[4]	IN: None OON: $2,000/$4,000
OUT-OF-POCKET MAXIMUM[2]	IN: $6,450/$12,900 OON: $11,000/$23,000	IN and OON combined: $6,850/$13,700	IN and OON combined: Medical: $5,450/$10,900 Rx: $1,000/$2,000
OFFICE VISIT	IN: Preventive: $0 Primary Care: $60 after deductible Specialist: $60 after deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 Primary Care: $25 after deductible Specialist: $40 after deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: $0 EBT: $15 SBT: $25 BBT: $45 Other Network Provider: $45 OON: 20% coinsurance after deductible
EMERGENCY ROOM	$750 after in-network deductible	Deductible	$150
INPATIENT ADMISSIONS[5]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: EBT: $250 SBT: $500 ($300 for select hospitals)[8] BBT: $1,000 OON: 20% coinsurance after deductible
SURGICAL DAY CARE[5]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: EBT: $150 SBT: $250 BBT: $500 OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	IN: $1,000 after deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: EBT: $75 SBT: $150 BBT: $250 Other Network Provider: $75 OON: 20% coinsurance after deductible
PRESCRIPTION DRUGS	After deductible IN: Retail: $15/50% coinsurance/50% coinsurance Mail: $30/50% coinsurance/ 50% coinsurance OON: $30/50% coinsurance/ 50% coinsurance Mail: Not covered	After deductible IN: Retail: $10/$25/$45 Mail: $20/$50/$135 OON: Retail: $20/$50/$90 Mail: Not covered	IN: Retail: $15/$30/$50 Mail: $30/$60/$150 OON: Retail: $30/$60/$100 Mail: Not covered
HOSPITAL CHOICE COST SHARING[6]	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 Options Deductible II v.5[7]	Preferred Blue® PPO Options Deductible III v.5[7]
DEDUCTIBLE[1]	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[2]	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: $20 SBT: $35 BBT: $55 Other Network Provider: $55 OON: 20% coinsurance after deductible	IN: Preventive: $0 EBT: $20 SBT: $35 BBT: $55 Other Network Provider: $55 OON: 20% coinsurance after deductible
EMERGENCY ROOM	$250	$250
INPATIENT ADMISSIONS[5]	IN: EBT: $500 SBT: $500 after deductible ($550 for select hospitals)[8] BBT: $1,500 after deductible OON: 20% coinsurance after deductible	IN: EBT: Deductible SBT: $500 after deductible ($50 after deductible for select hospitals)[8] BBT: $1,500 after deductible OON: 20% coinsurance after deductible
SURGICAL DAY CARE[5]	IN: EBT: $500 SBT: $500 after deductible ($550 for select hospitals)[8] BBT: $1,500 after deductible OON: 20% coinsurance after deductible	IN: EBT: Deductible SBT: $500 after deductible ($50 after deductible for select hospitals)[8] BBT: $1,500 after deductible OON: 20% coinsurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS[5]	IN: EBT: $75 SBT: $75 after deductible 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: $20/$40/$60/$120 Mail: $40/$80/$120/$360 OON: Retail: $40/$80/$120/$240 Mail: Not covered	IN: Retail: $15/$30/$60/$120 Mail: $30/$60/$120/$360 OON: Retail: $30/$60/$120/$240 Mail: Not covered
HOSPITAL CHOICE COST SHARING[6]	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.

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®[1] (ESI), our mail order pharmacy. Normal prescription guidelines apply.

FOOTNOTES

1. The two deductible amounts refer to individual and family per plan year unless otherwise noted.
2. The two out-of-pocket maximum amounts refer to individual and family per plan year unless otherwise noted. The out-of-pocket maximum amounts include copayments, coinsurance, and deductible, including costs for covered prescription drugs.
3. Entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.
4. 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.
5. This is the cost sharing for services rendered at hospitals other than those that are designated as higher cost.
6. 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. This applies to in-network services only.
7. 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.
8. 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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