

GETTING MORE. NOW THERE'S A PLAN.

2-50 HMO
& PPO

Accounts with 2-50 Enrolled Subscribers and 50 or Fewer Full-Time Employees
Effective on anniversary dates on or after January 1, 2022



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



*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.

NEW PLAN DESIGNS FOR 2022

We're pleased to introduce two new, lower-premium plans, effective January 1, 2022:

- **HMO Blue New England \$5,000 Deductible**
- **Preferred Blue® PPO \$2,500 Deductible**

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

HOME FITNESS EQUIPMENT

To help employers support their employees' diverse lifestyles and fitness journeys, we're expanding our popular Fitness Program to include home fitness equipment. Members can be reimbursed up to the standard \$150 per calendar year for items such as stationary bikes, weights, exercise bands, treadmills, and fitness machines.

90-DAY RETAIL DISPENSING

To allow members more convenience and choice in filling maintenance medications (also known as long-term medications), we're adding the option to fill 90-day supplies of prescription medications at participating retail pharmacies. Retail drugs are available in a 90-day supply at three times the standard retail cost share.

TELEHEALTH UPDATE

Throughout the COVID-19 pandemic, our priority has been to make sure members can easily and safely access the health care they need. Moving forward, our goal is to allow members continued telehealth access, as they've come to rely on this option to meet their medical and mental health care needs, so we'll be:

- Changing our telehealth benefit to be administered as a site of care for all members.
- Allowing members to see providers for either an in-person or telehealth visit for appropriate, covered services.
- Enabling the member cost share for a covered telehealth visit (any copay, co-insurance, or deductible) to be the same as if the care were obtained in person.

All commercial Blue Cross members will have telehealth coverage included in their plan when accessed through a Blue Network provider (exclusions: Medicare Advantage, FEP, and Medex®). Well Connection, which provides access to a supplemental network of urgent care and mental health providers, is included for fully insured accounts and available to ASC accounts for a fee.

THE AFFORDABLE CARE ACT (ACA) OUT-OF-POCKET MAXIMUM AND INTERNAL REVENUE SERVICE (IRS) COST-OF-LIVING ADJUSTMENTS FOR 2022

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 2022

Plan Type	Individual Coverage	Family Coverage
HSA QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS	\$7,050	\$14,100
NON-HSA QUALIFIED HEALTH PLANS	\$8,700	\$17,400

MINIMUM DEDUCTIBLE AMOUNTS FOR 2022

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

COST SHARE CHANGES FOR 2022

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

Changes for 2022	Details
PHARMACY BENEFIT CHANGE	Apply 6 tier pharmacy benefit with preferred brand specialty medications in Tier 5 and non-preferred brand specialty medications in Tier 6. Tiers 5 and 6 will have a 50% co-insurance with dollar maximums. Specialty medications are available through our network of specialty pharmacies.



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 in 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.* For more information, visit bluecrossma.com/hospitalchoice or contact your account executive or broker.

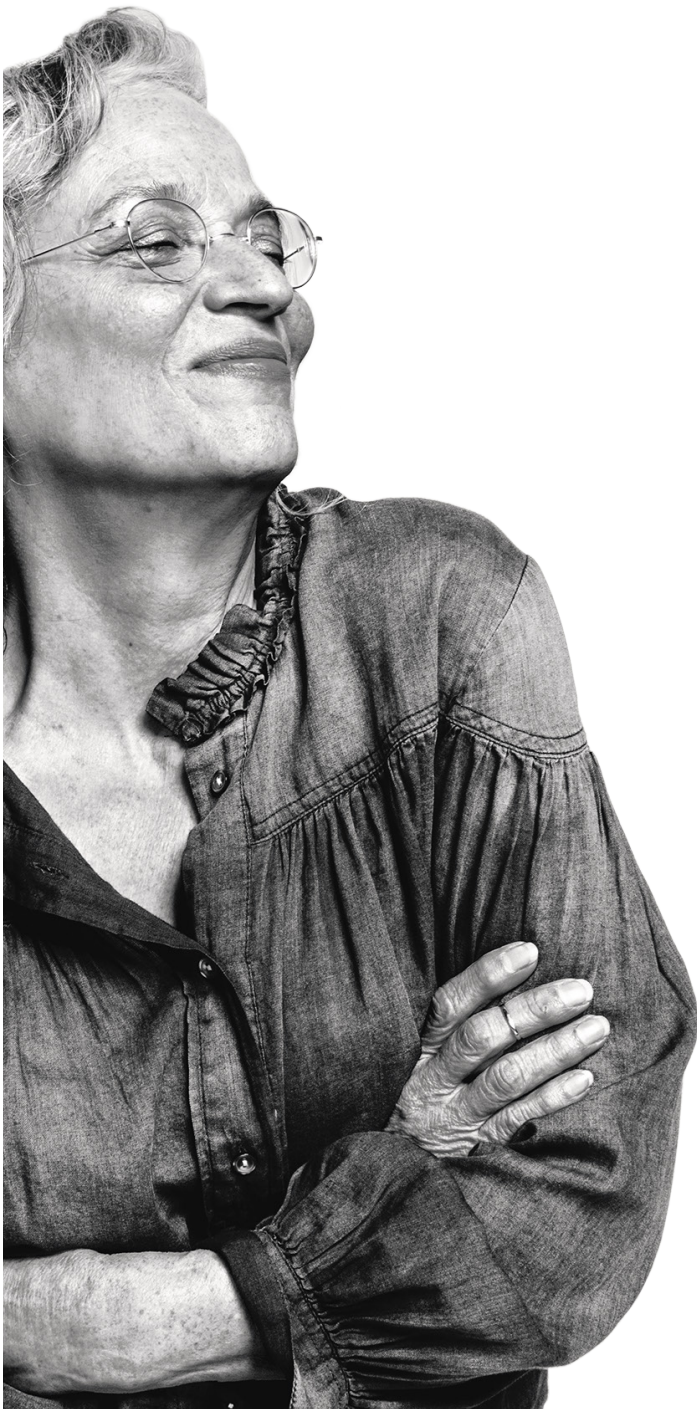
Blue Options (indicated in gray)

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 (copay, co-insurance, and/or deductible) 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 & Estimate Costs** tool at bluecrossma.com/findadoctor and select **HMO Blue New England Options v.5** or **Preferred Blue PPO Options v.5**.

HMO Blue Select (indicated in 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 & Estimate Costs** tool at bluecrossma.com/findadoctor and select **HMO Blue Select**.

*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.



HMO

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



	HMO Blue New England Premier Value	HMO Blue New England \$500 Deductible with Hospital Choice Cost Sharing	HMO Blue New England \$1,000 Deductible with Copayment
DEDUCTIBLE ²	Inpatient: \$1,000/\$2,500	\$500/\$1,000	\$1,000/\$2,000
OUT-OF-POCKET MAXIMUM ³	\$8,150/\$16,300	\$8,150/\$16,300	\$8,000/\$16,000
OFFICE VISIT	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$45	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$45	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$50
EMERGENCY ROOM	\$250	\$150	\$250
INPATIENT ADMISSIONS	Deductible	Deductible	\$550 after deductible
SURGICAL DAY CARE	\$500	Deductible	\$250 after deductible
LABS ⁷	Hospital: \$40 Other network provider: \$0	\$35 after deductible	Hospital: \$40 after deductible Other network provider: Deductible
X-RAYS ⁷	Hospital: \$40 Other network provider: \$0	\$35 after deductible	Hospital: \$80 after deductible Other network provider: Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	Hospital: \$300 Other network provider: \$50	Deductible	Hospital: \$300 after deductible Other network provider: \$50 after deductible
PRESCRIPTION DRUGS	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675
HOSPITAL CHOICE COST SHARING ⁸	Not Applicable	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$70 X-rays and other imaging tests: \$135 MRI/CT/PET/NC: \$450 PT/OT/ST: \$80	Not Applicable

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

KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
PT/OT/ST: Physical/Occupational/Speech Therapy VBB: Value-Based Benefits OON: Out-of-Network

**FOOTNOTES LOCATED
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	HMO Blue New England \$1,500 Deductible with Hospital Choice Cost Sharing	HMO Blue New England \$2,000 Deductible	HMO Blue New England Options Deductible II v.5 ⁹
DEDUCTIBLE ²	\$1,500/\$3,000	\$2,000/\$4,000	\$1,000/\$2,000
OUT-OF-POCKET MAXIMUM ³	\$8,150/\$16,300	\$8,150/\$16,300	\$8,150/\$16,300
OFFICE VISIT	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$45	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$45	Preventive: \$0 PCP: ¹ EBT: \$25 SBT: \$40 BBT: \$55 Specialist: ¹ \$55
EMERGENCY ROOM	\$250	\$250	\$350
INPATIENT ADMISSIONS	Deductible	Deductible	EBT: Deductible SBT: \$750 after deductible (\$50 after deductible for select hospitals ¹⁰) BBT: \$2,000 after deductible
SURGICAL DAY CARE	Deductible	Deductible	EBT: Deductible SBT: \$750 after deductible (\$50 after deductible for select hospitals ¹⁰) BBT: \$2,000 after deductible
LABS ⁷	\$35 after deductible	Hospital: \$60 after deductible Other network provider: Deductible	EBT: \$15 after deductible SBT: \$50 after deductible BBT: \$70 after deductible Other network provider: \$15
X-RAYS ⁷	\$35 after deductible	Hospital: \$100 after deductible Other network provider: Deductible	EBT: \$15 after deductible SBT: \$50 after deductible BBT: \$70 after deductible Other network provider: \$15
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	\$75 after deductible	Hospital: \$300 after deductible Other network provider: \$50 after deductible	EBT: Deductible SBT: \$150 after deductible BBT: \$500 after deductible Other network provider: \$0
PRESCRIPTION DRUGS	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$175/\$250/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750
HOSPITAL CHOICE COST SHARING ⁸	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$70 X-rays and other imaging tests: \$135 MRI/CT/PET/NC: \$525 PT/OT/ST: \$80	Not Applicable	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT	INDICATES CHANGES TO PLAN
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KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
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FOOTNOTES LOCATED
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	HMO Blue New England \$2,000 Deductible with Hospital Choice Cost Sharing	HMO Blue Select \$1,000 Deductible with Copayment	HMO Blue Select \$2,000 Deductible
DEDUCTIBLE ²	\$2,000/\$4,000	\$1,000/\$2,000	\$2,000/\$4,000
OUT-OF-POCKET MAXIMUM ³	\$8,150/\$16,300	\$7,350/\$14,700	\$8,150/\$16,300
OFFICE VISIT	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$45	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$50	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$45
EMERGENCY ROOM	\$150	\$250	\$250
INPATIENT ADMISSIONS	Deductible	\$550 after deductible	Deductible
SURGICAL DAY CARE	Deductible	\$250 after deductible	Deductible
LABS ⁷	\$35 after deductible	\$60 after deductible	\$15 after deductible
X-RAYS ⁷	\$35 after deductible	\$60 after deductible	\$15 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	\$50 after deductible	\$250 after deductible	\$75 after deductible
PRESCRIPTION DRUGS	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675
HOSPITAL CHOICE COST SHARING ⁸	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$70 X-rays and other imaging tests: \$135 MRI/CT/PET/NC: \$500 PT/OT/ST: \$80	Not Applicable	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT	INDICATES CHANGES TO PLAN
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KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
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	HMO Blue New England Options Deductible III v.5 ⁹	HMO Blue New England \$2,000 Deductible with Copayment	HMO Blue New England Total Deductible with Rx
DEDUCTIBLE ²	\$2,000/\$4,000	\$2,000/\$4,000	\$3,500/\$7,000
OUT-OF-POCKET MAXIMUM ³	\$8,150/\$16,300	\$8,150/\$16,300	\$3,500/\$7,000
OFFICE VISIT	Preventive: \$0 PCP: ¹ EBT: \$25 SBT: \$40 BBT: \$55 Specialist: ¹ \$55	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$45	Preventive: \$0 PCP: ¹ Deductible Specialist: ¹ Deductible
EMERGENCY ROOM	\$350	\$750 after deductible	Deductible
INPATIENT ADMISSIONS	EBT: Deductible SBT: \$750 after deductible (\$50 after deductible for select hospitals ¹⁰) BBT: \$2,000 after deductible	\$550 after deductible	Deductible
SURGICAL DAY CARE	EBT: Deductible SBT: \$750 after deductible (\$50 after deductible for select hospitals ¹⁰) BBT: \$2,000 after deductible	\$250 after deductible	Deductible
LABS ⁷	EBT: \$15 after deductible SBT: \$50 after deductible BBT: \$70 after deductible Other network provider: \$15	Hospital: \$80 after deductible Other network provider: Deductible	Deductible
X-RAYS ⁷	EBT: \$15 after deductible SBT: \$50 after deductible BBT: \$70 after deductible Other network provider: \$15	Hospital: \$125 after deductible Other network provider: Deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	EBT: Deductible SBT: \$150 after deductible BBT: \$500 after deductible Other network provider: \$0	Hospital: \$350 after deductible Other network provider: \$75 after deductible	Deductible
PRESCRIPTION DRUGS	Retail: \$10/\$45/\$175/\$250/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750	Retail: \$10/\$45/\$175/\$250/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675
HOSPITAL CHOICE COST SHARING ⁸	Not Applicable	Not Applicable	Not Applicable

LEGEND:
HOSPITAL CHOICE COST SHARING
BLUE OPTIONS
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	HMO Blue New England \$3,000 Deductible	HMO Blue New England Saver \$2,000 (HSA Compliant)	HMO Blue New England Basic Copayment
DEDUCTIBLE ²	\$3,000/\$6,000	\$2,000/\$4,000 ⁴	\$2,000/\$4,000
OUT-OF-POCKET MAXIMUM ³	\$8,150/\$16,300	\$6,700/\$13,400	\$8,150/\$16,300
OFFICE VISIT	Preventive: \$0 PCP: ¹ \$40 Specialist: ¹ \$55	Preventive: \$0 PCP: ¹ \$25 after deductible Specialist: ¹ \$45 after deductible	Preventive: \$0 PCP: ¹ \$40 Specialist: ¹ \$60
EMERGENCY ROOM	\$750 after deductible	\$250 after deductible	\$1,000 after deductible
INPATIENT ADMISSIONS	\$500 after deductible	\$250 after deductible	\$1,000 after deductible
SURGICAL DAY CARE	\$500 after deductible	\$250 after deductible	\$1,000 after deductible
LABS ⁷	Hospital: \$60 after deductible Other network provider: Deductible	Hospital: \$60 after deductible Other network provider: Deductible	Hospital: \$60 after deductible Other network provider: Deductible
X-RAYS ⁷	Hospital: \$100 after deductible Other network provider: Deductible	Hospital: \$100 after deductible Other network provider: Deductible	Hospital: \$100 after deductible Other network provider: Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	Hospital: \$300 after deductible Other network provider: \$50 after deductible	Hospital: \$400 after deductible Other network provider: \$75 after deductible	Hospital: \$1,000 after deductible Other network provider: \$750 after deductible
PRESCRIPTION DRUGS	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	After deductible ⁶ Retail: \$10/\$45/\$175/\$250/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675
HOSPITAL CHOICE COST SHARING ⁸	Not Applicable	Not Applicable	Not Applicable

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

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	HMO Blue New England \$3,000 Deductible with Hospital Choice Cost Sharing	HMO Blue New England \$4,500 Deductible	NEW HMO Blue New England \$5,000 Deductible
DEDUCTIBLE ²	\$3,000/\$6,000	\$4,500/\$9,000	\$5,000/\$10,000
OUT-OF-POCKET MAXIMUM ³	\$8,150/\$16,300	\$8,150/\$16,300	\$8,350/\$16,700
OFFICE VISIT	Preventive: \$0 PCP: ¹ \$30 Specialist: ¹ \$40	Preventive: \$0 PCP: ¹ \$40 Specialist: ¹ \$55	Preventive: \$0 PCP: ¹ \$40 Specialist: ¹ \$65
EMERGENCY ROOM	\$500 after deductible	\$500 after deductible	\$500 after deductible
INPATIENT ADMISSIONS	\$500 after deductible	\$500 after deductible	\$1,000 after deductible
SURGICAL DAY CARE	\$500 after deductible	\$500 after deductible	\$750 after deductible
LABS ⁷	\$35 after deductible	Hospital: \$60 after deductible Other network provider: Deductible	Hospital: \$60 after deductible Other network provider: Deductible
X-RAYS ⁷	\$40 after deductible	Hospital: \$100 after deductible Other network provider: Deductible	Hospital: \$75 after deductible Other network provider: Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	\$500 after deductible	Hospital: \$300 after deductible Other network provider: \$50 after deductible	Hospital: \$500 after deductible Other network provider: \$150 after deductible
PRESCRIPTION DRUGS	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675
HOSPITAL CHOICE COST SHARING ⁸	After deductible Inpatient: \$1,500 SDC: \$1,500 Labs: \$70 X-rays and other imaging tests: \$140 MRI/CT/PET/NC: \$950 PT/OT/ST: \$75	Not Applicable	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT	 INDICATES CHANGES TO PLAN
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	HMO Blue Select \$2,000 Deductible with Copayment	HMO Blue New England Saver \$3,000 (HSA Compliant)	HMO Blue Select \$3,000 Deductible
DEDUCTIBLE ²	\$2,000/\$4,000	\$3,000/\$6,000 ⁵	\$3,000/\$6,000
OUT-OF-POCKET MAXIMUM ³	\$8,150/\$16,300	\$6,700/\$13,400	\$8,150/\$16,300
OFFICE VISIT	Preventive: \$0 PCP: ¹ \$25 Specialist: ¹ \$45	Preventive: \$0 PCP: ¹ \$35 after deductible Specialist: ¹ \$50 after deductible	Preventive: \$0 PCP: ¹ \$40 Specialist: ¹ \$55
EMERGENCY ROOM	\$750 after deductible	\$250 after deductible	\$750 after deductible
INPATIENT ADMISSIONS	\$500 after deductible	Deductible	\$500 after deductible
SURGICAL DAY CARE	\$250 after deductible	Deductible	\$500 after deductible
LABS ⁷	\$55 after deductible	Hospital: \$35 after deductible Other network provider: Deductible	\$40 after deductible
X-RAYS ⁷	\$55 after deductible	Hospital: \$35 after deductible Other network provider: Deductible	\$40 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	\$200 after deductible	Hospital: \$150 after deductible Other network provider: Deductible	\$300 after deductible
PRESCRIPTION DRUGS	Retail: \$10/\$45/\$175/\$250/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750	After deductible ⁶ Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675
HOSPITAL CHOICE COST SHARING ⁸	Not Applicable	Not Applicable	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT	INDICATES CHANGES TO PLAN
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KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
PT/OT/ST: Physical/Occupational/Speech Therapy VBB: Value-Based Benefits OON: Out-of-Network

FOOTNOTES LOCATED
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	HMO Blue Select Saver \$2,000 (HSA Compliant)	HMO Blue New England Saver \$3,000 with Hospital Choice Cost Sharing (HSA Compliant)	HMO Blue New England Saver \$4,500 (HSA Compliant)
DEDUCTIBLE ²	\$2,000/\$4,000 ⁴	\$3,000/\$6,000 ⁵	\$4,500/\$9,000 ⁵
OUT-OF-POCKET MAXIMUM ³	\$6,700/\$13,400	\$6,700/\$13,400	\$6,350/\$12,700
OFFICE VISIT	Preventive: \$0 PCP: ¹ \$25 after deductible Specialist: ¹ \$45 after deductible	Preventive: \$0 PCP: ¹ \$35 after deductible Specialist: ¹ \$50 after deductible	Preventive: \$0 PCP: ¹ \$35 after deductible Specialist: ¹ \$50 after deductible
EMERGENCY ROOM	\$250 after deductible	\$250 after deductible	\$250 after deductible
INPATIENT ADMISSIONS	\$250 after deductible	Deductible	\$250 after deductible
SURGICAL DAY CARE	\$150 after deductible	Deductible	\$250 after deductible
LABS ⁷	\$40 after deductible	Deductible	Hospital: \$35 after deductible Other network provider: Deductible
X-RAYS ⁷	\$40 after deductible	Deductible	Hospital: \$35 after deductible Other network provider: Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	\$250 after deductible	Deductible	Hospital: \$150 after deductible Other network provider: Deductible
PRESCRIPTION DRUGS	After deductible ⁶ Retail: \$10/\$45/\$175/\$250/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750	After deductible ⁶ Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675	After deductible ⁶ Retail: \$10/\$45/\$175/\$250/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750
HOSPITAL CHOICE COST SHARING ⁸	Not Applicable	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$450 PT/OT/ST: \$80	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT	INDICATES CHANGES TO PLAN
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KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
PT/OT/ST: Physical/Occupational/Speech Therapy VBB: Value-Based Benefits OON: Out-of-Network

FOOTNOTES LOCATED
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HMO Blue New England Basic Saver (HSA Compliant)

DEDUCTIBLE ²	\$3,350/\$6,550 ⁵
OUT-OF-POCKET MAXIMUM ³	\$6,550/\$13,100
OFFICE VISIT	Preventive: \$0 PCP: ¹ \$40 after deductible Specialist: ¹ \$60 after deductible
EMERGENCY ROOM	\$1,000 after deductible
INPATIENT ADMISSIONS	\$1,000 after deductible
SURGICAL DAY CARE	\$1,000 after deductible
LABS ⁷	Hospital: \$80 after deductible Other network provider: Deductible
X-RAYS ⁷	Hospital: \$125 after deductible Other network provider: Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	Hospital: \$1,000 after deductible Other network provider: \$750 after deductible
PRESCRIPTION DRUGS	After deductible ⁶ Retail: \$10/\$45/\$175/\$250/50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750
HOSPITAL CHOICE COST SHARING ⁸	Not Applicable

LEGEND:

HOSPITAL CHOICE COST SHARING

BLUE OPTIONS

BLUE SELECT

INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
PT/OT/ST: Physical/Occupational/Speech Therapy VBB: Value-Based Benefits OON: Out-of-Network

FOOTNOTES LOCATED
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PPO

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



	Preferred Blue® PPO \$1,500 Deductible	Preferred Blue® PPO Saver \$2,000 (HSA Compliant)	NEW Preferred Blue® PPO \$2,500 Deductible
DEDUCTIBLE ²	IN: \$1,500/\$3,000 OON: \$4,500/\$9,000	IN: \$2,000/\$4,000 ⁴ OON: \$5,000/\$10,000 ⁴	IN: \$2,500/\$5,000 OON: \$5,500/\$11,000
OUT-OF-POCKET MAXIMUM ³	IN: \$8,150/\$16,300 OON: \$16,300/\$32,600	IN: \$6,700/\$13,400 OON: \$13,400/\$26,800	IN: \$8,350/\$16,700 OON: \$16,700/\$33,400
OFFICE VISIT	IN: Preventive: \$0 Primary Care: ¹ \$25 after deductible Specialist: ¹ \$45 after deductible OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: ¹ \$30 after deductible Specialist: ¹ \$45 after deductible OON: 20% co-insurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: ¹ \$35 after deductible Specialist: ¹ \$45 after deductible OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$200 after in-network deductible	\$250 after in-network deductible	\$250 after in-network deductible
INPATIENT ADMISSIONS	IN: 10% co-insurance after deductible OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 20% co-insurance after deductible
SURGICAL DAY CARE	IN: \$250 after deductible OON: 20% co-insurance after deductible	IN: \$250 after deductible OON: 20% co-insurance after deductible	IN: \$500 after deductible OON: 20% co-insurance after deductible
LABS ⁷	IN: Hospital: \$60 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible	IN: Hospital: \$60 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible	IN: Hospital: \$50 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible
X-RAYS ⁷	IN: Hospital: \$80 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible	IN: Hospital: \$80 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible	IN: Hospital: \$50 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	IN: Hospital: \$120 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible	IN: Hospital: \$400 after deductible Other Network Provider: \$75 after deductible OON: 20% co-insurance after deductible	IN: Hospital: \$400 after deductible Other Network Provider: \$150 after deductible OON: 20% co-insurance after deductible
PRESCRIPTION DRUGS	IN: Retail: \$10/\$45/\$150/\$225/50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ⁸ \$10/\$45/\$150/\$675 OON: Retail: \$20/\$90/\$300/\$450 Mail: Not covered	After in-network deductible ⁶ IN: Retail: \$10/\$45/\$175/\$250/50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ⁸ \$10/\$45/\$175/\$750 After out-of-network deductible ⁶ OON: Retail: \$20/\$90/\$350/\$500 Mail: Not covered	IN: Retail: \$10/\$45/\$150/\$225/50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ⁸ \$10/\$45/\$150/\$675 OON: Retail: \$20/\$90/\$300/\$450 Mail: Not covered
HOSPITAL CHOICE COST SHARING ⁸	Not Applicable	Not Applicable	Not Applicable

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

KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
PT/OT/ST: Physical/Occupational/Speech Therapy VBB: Value-Based Benefits OON: Out-of-Network

**FOOTNOTES LOCATED
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	Preferred Blue® PPO \$3,000 Deductible with Hospital Choice Cost Sharing	Preferred Blue® PPO Saver \$3,000 (HSA Compliant)	Preferred Blue® PPO \$4,500 Deductible
DEDUCTIBLE ²	IN: \$3,000/\$7,500 OON: \$6,000/\$13,000	IN: \$3,000/\$6,000 ⁵ OON: \$6,000/\$12,000 ⁵	IN: \$4,500/\$9,000 OON: \$7,500/\$15,000
OUT-OF-POCKET MAXIMUM ³	IN: \$8,150/\$16,300 OON: \$16,300/\$32,600	IN: \$6,700/\$13,400 OON: \$13,400/\$26,800	IN: \$8,150/\$16,300 OON: \$16,300/\$32,600
OFFICE VISIT	IN: Preventive: \$0 Primary Care: ¹ \$35 after deductible Specialist: ¹ \$45 after deductible OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: ¹ \$30 after deductible Specialist: ¹ \$45 after deductible OON: 20% co-insurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: ¹ \$35 after deductible Specialist: ¹ \$45 after deductible OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$500 after in-network deductible	\$150 after in-network deductible	\$1,000 after in-network deductible
INPATIENT ADMISSIONS	IN: 10% co-insurance after deductible OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 20% co-insurance after deductible
SURGICAL DAY CARE	IN: \$500 after deductible OON: 20% co-insurance after deductible	IN: \$250 after deductible OON: 20% co-insurance after deductible	IN: \$500 after deductible OON: 20% co-insurance after deductible
LABS ⁷	IN: \$35 after deductible OON: 20% co-insurance after deductible	IN: Hospital: \$40 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible	IN: Hospital: \$100 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible
X-RAYS ⁷	IN: \$35 after deductible OON: 20% co-insurance after deductible	IN: Hospital: \$40 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible	IN: Hospital: \$250 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	IN: \$250 after deductible OON: 20% co-insurance after deductible	IN: Hospital: \$400 after deductible Other Network Provider: \$75 after deductible OON: 20% co-insurance after deductible	IN: Hospital: \$400 after deductible Other Network Provider: \$75 after deductible OON: 20% co-insurance after deductible
PRESCRIPTION DRUGS	IN: Retail: \$10/\$45/\$175/\$250/50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750 OON: Retail: \$20/\$90/\$350/\$500 Mail: Not covered	After in-network deductible ⁶ IN: Retail: \$10/\$45/\$150/\$225/50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675 After out-of-network deductible ⁶ OON: Retail: \$20/\$90/\$300/\$450 Mail: Not covered	IN: Retail: \$10/\$45/\$150/\$225/ 50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$300/\$675 VBB: ¹ \$10/\$45/\$150/\$675 OON: Retail: \$20/\$90/\$300/\$450 Mail: Not covered
HOSPITAL CHOICE COST SHARING ⁸	After deductible Inpatient: 20% co-insurance SDC: \$1,500 Labs: \$70 X-rays and other imaging tests: \$135 MRI/CT/PET/NC: \$700 PT/OT/ST: \$80	Not Applicable	Not Applicable

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

KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
PT/OT/ST: Physical/Occupational/Speech Therapy VBB: Value-Based Benefits OON: Out-of-Network

**FOOTNOTES LOCATED
ON THE LAST PAGE**

**Preferred Blue® PPO Saver \$4,500
(HSA Compliant)**

DEDUCTIBLE ²	IN: \$4,500/\$9,000 ⁵ OON: \$7,500/\$15,000 ⁵
OUT-OF-POCKET MAXIMUM ³	IN: \$6,350/\$12,700 OON: \$12,700/\$25,400
OFFICE VISIT	IN: Preventive: \$0 Primary Care: ¹ \$30 after deductible Specialist: ¹ \$45 after deductible OON: 20% co-insurance after deductible (no deductible for preventive care)
EMERGENCY ROOM	\$150 after in-network deductible
INPATIENT ADMISSIONS	IN: 10% co-insurance after deductible OON: 20% co-insurance after deductible
SURGICAL DAY CARE	IN: \$500 after deductible OON: 20% co-insurance after deductible
LABS ⁷	IN: Hospital: \$40 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible
X-RAYS ⁷	IN: Hospital: \$40 after deductible Other Network Provider: Deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS ⁷	IN: Hospital: \$400 after deductible Other Network Provider: \$75 after deductible OON: 20% co-insurance after deductible
PRESCRIPTION DRUGS	After in-network deductible ⁶ IN: Retail: \$10/\$45/\$175/\$250/50% with \$350 Max/50% with \$500 Max Mail: \$20/\$90/\$350/\$750 VBB: ¹ \$10/\$45/\$175/\$750 After out-of-network deductible ⁶ OON: Retail: \$20/\$90/\$350/\$500 Mail: Not covered
HOSPITAL CHOICE COST SHARING ⁸	Not Applicable

LEGEND:

HOSPITAL CHOICE COST SHARING

BLUE OPTIONS

INDICATES CHANGES TO PLAN

KEY: EBT: Enhanced Benefits Tier SBT: Standard Benefits Tier BBT: Basic Benefits Tier SDC: Surgical Day Care
PT/OT/ST: Physical/Occupational/Speech Therapy VBB: Value-Based Benefits OON: Out-of-Network

FOOTNOTES LOCATED
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MEDICARE CREDITABLE COVERAGE

All plans in this chart meet Medicare Creditable Coverage prescription drug coverage requirements, except HMO Blue New England \$5,000 Deductible. Creditable Coverage means that the member's prescription drug coverage is as good as or better than the standard Medicare Part D plan.

MINIMUM CREDITABLE COVERAGE

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

LOW-COST GENERIC MEDICATION BENEFIT

With all plans, members can get a 90-day supply of select generic medications for only \$9 through the mail order pharmacy. Normal prescription guidelines apply.

SELECT HOME DELIVERY

Members in plans with Select Home Delivery need to select whether they want to fill their maintenance medications through the mail order pharmacy or at a retail pharmacy. Members who fill their prescriptions through the mail order pharmacy can save time and money on a 90-day supply of their medications. Members who choose to fill their prescriptions at a retail pharmacy need to notify Express Scripts[®], an independent company that administers the pharmacy benefit on behalf of Blue Cross Blue Shield of Massachusetts, before their third medication fill, or they'll be responsible for the full cost of their medication. Select Home Delivery is included in all plans listed in this guide.

VALUE-BASED BENEFITS (VBB)

The VBB¹ approach to managing costs focuses on improving the health of members who have certain chronic conditions. These benefits are included in some plans listed in this guide.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS ALLOWS SMALL EMPLOYER GROUPS¹¹ WITH TWO OR MORE ENROLLED EMPLOYEES TO OFFER UP TO TWO MEDICAL PLANS

Please see our Underwriting Guidelines for this type of arrangement:

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

FOOTNOTES

1. Value-Based Benefits:

- Members will pay nothing for the first two diabetic monitoring visits per calendar year. These are services such as diabetes evaluation and management services, including diabetic eye exams and foot care.
- Members will pay the same cost share for a 90-day supply of medication when purchased at the mail order pharmacy as they do for a 30-day supply when purchased from a retail pharmacy. For 4-Tier pharmacy benefits, this applies to a specific list of Tier 1, Tier 2, and Tier 3 medications used in the treatment of asthma, coronary artery disease/cardiovascular disease, and diabetes, as well as a comorbidity of depression.
- Members will pay nothing for certain Tier 1 and Tier 2 smoking cessation products when purchased at either at a retail pharmacy or mail order pharmacy.

2. The two deductible amounts refer to per member and per family per plan year, unless otherwise noted.

3. The two out-of-pocket maximum amounts refer to per member and per family per plan year, unless otherwise noted. The out-of-pocket maximum amounts include copays, co-insurance, and deductible, including costs for covered prescription drugs.

4. Entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.

5. The family deductible can be met through any combination of eligible costs from members on the same family plan. Each member is only responsible for their individual deductible.

6. Overall deductible does not apply to preventive or Value-Based Benefits drugs.

7. Cost sharing for these benefits may be higher when performed at a general hospital or hospital-owned outpatient facility.

8. Higher-cost hospitals are: Baystate Medical Center, Brigham and Women's Hospital, Cape Cod Hospital, Boston Children's Hospital (other than locations at Lexington, Peabody, and Waltham), Dana-Farber Cancer Institute, Fairview Hospital, Massachusetts General Hospital, and UMass Memorial Medical Center – Memorial and University Campuses.

9. Outside Massachusetts, the lower Enhanced Benefits Tier copayment applies to any network provider who is listed as a general practitioner, pediatrician, obstetrician/gynecologist, nurse practitioner, rural health center, limited services clinic, or general hospital. In New Hampshire, a Tier 1 provider equates to an Enhanced Benefits Tier provider and a Tier 2 provider equates to a Standard Benefits Tier provider.

10. To provide geographic access to members, the lower Standard Benefits Tier copayment applies to Athol Memorial Hospital, Baystate Franklin Medical Center, Berkshire Medical Center, Falmouth Hospital, Martha's Vineyard Hospital, and Nantucket Cottage Hospital.

11. Small employer group: "Eligible small business" or "group", any sole proprietorship, firm, corporation, partnership, or association actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed from one to not more than fifty full-time equivalent employees, the majority of whom worked in the commonwealth; provided, however, that a health carrier may offer health insurance to a business of more than fifty employees in accordance with the provisions of this chapter. In determining the number of full-time equivalent employees, a business shall be considered to be one eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of this chapter that apply to an eligible small business shall continue to apply through the end of the rating period in which an eligible insured no longer meets the requirements of this definition. An eligible small business that exists within a Multiple Employer Welfare Arrangement (MEWA) shall be subject to this chapter.

Questions?

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



MASSACHUSETTS