

100+ HMO,  
PPO &  
EPO

# GETTING MORE. NOW THERE'S A PLAN.

Accounts with 100+ Eligible Employees and Enrolled Subscribers  
Effective on anniversary dates on or after January 1, 2023



# PLANS THAT FIT YOUR EMPLOYEES' NEEDS

Choosing the right health plan is essential to attracting and retaining top talent. That's where we come in. Our comprehensive plans will help you feel confident, knowing your employees have access to the benefits and services that meet their unique needs.

## WHAT YOU CAN EXPECT



### Exceptional Member Experiences

For the sixth year in a row, J.D. Power ranked us #1 in member satisfaction among all commercial health plans in Massachusetts.\*



### Top-rated Tools and Resources

From MyBlue to Team Blue, your employees have 24/7 access to their benefits, and a coordinated team ready to spring into action when questions arise.



### Unparalleled Access

With the largest network of providers in the country, we can consistently offer the lowest total cost of care.



### Cutting-Edge Innovation

We go beyond keeping up to date with health care reform guidelines, and make sure our plans are ahead of the curve to maximize coverage and lower costs.

## FIND THE RIGHT PLAN FOR YOUR EMPLOYEES

Read this brochure to learn about the upcoming changes to enhance our products and offerings, and to compare the benefits included in each of our plans.†



\*For J.D. Power 2022 award information, visit [jdpower.com/awards](https://www.jdpower.com/awards).

†Our plans feature more benefits than those listed in this brochure. To see more details about what's included in each plan, refer to the plan subscriber certificates.



# WHAT'S NEW FOR 2023

Here's what we're doing to keep our plans ahead of the curve. These updates are effective January 1, 2023, and upon renewal, unless otherwise noted.

## SOLUTIONS THAT DRIVE VALUE AND AFFORDABILITY

### VIRTUAL CARE TEAM

Getting care should be easy and affordable. That's why we created this feature that gives members the option to receive their primary care virtually by selecting a PCP that is designated as a Virtual Care Team provider. To ensure continuity of care, members who elect this model will be assigned their own dedicated Virtual Care Team that will help manage the member's health and coordinate in-person care with network providers when necessary. This feature is included in most of our plans at no additional cost.

#### Key Features:

- No cost for primary care and mental health services provided by the member's Virtual Care Team\*
- Convenient, concierge-like experience that helps members navigate the health care system — all from their preferred device
- Available to members nationwide
- Best-in-class virtual providers

#### How It Works:

Once a member enrolls in the program, they'll receive a welcome kit with connected medical devices, such as a blood pressure monitor, to use for virtual visits with their dedicated Virtual Care Team. Members can easily go online to schedule no-cost primary care and mental health visits with their team's providers and use in-app chat to connect with them anytime.

Their team will assess their health and, when necessary, prescribe medications or guide them through the next steps for follow-up care. When in-person care is needed, members have access to their plan's full network of providers. Their Virtual Care Team can recommend a provider that works for them, securely share medical records to ensure continuity of care, and even schedule the appointment on their behalf.



### COST-SHARE ASSISTANCE PROGRAM

The Cost-Share Assistance Program is an opt-in program that uses coupons from medication manufacturers to reduce the cost of eligible high-cost specialty medications for you and your employees. Once enrolled, most or all out-of-pocket costs are covered, and there's no need to change where or how you get prescriptions.

\*Before qualifying for no-cost virtual visits, HMO members must designate a Virtual Care Team provider as their Primary Care Provider (PCP) and Saver/HSA-eligible plan members must meet their deductible.

## NEW PLANS FOR YOU TO CHOOSE FROM

### Advantage Blue® Preferred

These Exclusive Provider Organization (EPO) plans offer access to our National BlueCard® network with out-of-network coverage for emergency care only.



#### Extensive Network

Includes over 1,000,000 providers and 6,100 hospitals in the U.S. and Puerto Rico



#### Easy to Use

Doesn't require a PCP or referrals, plus offers a single point of contact for administration of claims and services



#### Flexible Design

Available as a no-deductible plan, traditional deductible plan, or HSA-qualified, high-deductible plan

### Network Blue® Select Saver

This HSA-qualified, high-deductible health plan features a limited network of doctors and hospitals that provide high-quality care at a lower cost.



#### Cost Savings

Designed to offer savings to you and your employees



#### Local Access

Includes providers and hospitals throughout Massachusetts, except for Cape Cod and Islands



#### Curated Network

Includes a network of providers carefully chosen for meeting our benchmarks for quality and cost

## \$0 VISITS AT LIMITED SERVICE CLINICS

To increase convenient access to low-cost, high-quality care, we're offering this optional rider which allows members to visit limited service clinics at no cost. Limited service clinics, such as CVS Minute Clinics, are typically staffed by a nurse practitioner and are located within retail pharmacies. They can provide vaccinations and routine health checkups, as well as diagnosis and treatment for simple medical concerns.

Members on Saver plans must first meet their deductible for the copay or co-insurance to be waived.



## NEW PHARMACY BENEFIT MANAGER

We know how important our pharmacy benefit is to our members. That's why starting January 1, 2023, a new pharmacy benefit manager will be administering your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts. This change will help:



**Keep Pharmacy Costs Down  
for Accounts and Members**



**Provide More In-network  
Pharmacy Locations**



**Offer New Pharmacy Programs  
That Drive Better Health Outcomes  
for Our Members**

All accounts with pharmacy benefits will transition on January 1, 2023 regardless of renewal date, and all covered employees will receive new ID cards.

### CHOOSE THE PROGRAM THAT'S RIGHT FOR YOU

**Maintenance Choice Voluntary is included in your core benefits, while Maintenance Choice All Access is an opt-in. These programs are only available to self-insured (ASC) accounts.**

#### Maintenance Choice Voluntary

With Maintenance Choice Voluntary, you and your employees save money when your employees switch their maintenance medications to a 90-day prescription and fill them at a CVS Pharmacy retail location, or through the mail service pharmacy.

#### Maintenance Choice All Access

With Maintenance Choice All Access you can save up to 5% on pharmacy costs, compared with up to 1% for Maintenance Choice Voluntary. Maintenance Choice All Access requires members to switch their maintenance medications to 90-day fills at a CVS pharmacy retail location or through the mail service pharmacy, while Maintenance Choice Voluntary is optional for members.

#### How these programs help:



##### Lower Costs for You

You save on your total pharmacy costs.



##### Savings for Your Employees

Your employees pay the equivalent of one less copay for a 90-day fill.\*



##### Better Medication Adherence

Your employees are more likely to adhere to their medications.

\*In most cases for eligible medications

# FEDERAL MANDATES AND OTHER CHANGES

## BREAST PUMP SUPPLY MANDATE

Members will be eligible to receive breast pump replacement parts 90 days after the purchase of a breast pump and every 60 days following that date. These parts will be available at no additional cost to the member when purchased from an in-network durable medical equipment provider. Benefits won't be available if the parts are obtained from an out-of-network provider.

## BENEFIT ALIGNMENT CHANGES

These changes are part of our ongoing efforts to ensure benefit alignment across our products and plan designs.

### Short-Term Rehabilitation

To align with all other standard products, we're revising the combined physical and occupational therapy visit limit under the short-term rehabilitation benefit for our Blue Care Elect PPO and Advantage Blue EPO plans from 100 visits to 60. You have the option to customize these visit limits for your employees via rider.

### The Affordable Care Act (ACA) Out-of-Pocket Maximum and Internal Revenue Service (IRS) Cost-of-Living Adjustments for 2023

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 IRS's guidelines for HSA-compatible, high-deductible plans.

Employers with 100 or more employees can increase their out-of-pocket maximums to any dollar amount up to the ACA's 2023 limits or the IRS's new limits for Saver plans, which are HSA-compatible, high-deductible plans.

### ANNUAL OUT-OF-POCKET MAXIMUMS FOR 2023

Plan Type	Individual Coverage	Family Coverage
HSA-QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS	\$7,500	\$15,000
NON-HSA-QUALIFIED HEALTH PLANS	\$9,100	\$18,200

### MINIMUM DEDUCTIBLE AMOUNTS FOR 2023

Plan Type	Individual Coverage	Family Coverage
HSA-QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS	\$1,500	\$3,000

# 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](https://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 (copayments, co-insurance, 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 & Estimate Costs** tool at [bluecrossma.com/findadoctor](https://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](https://bluecrossma.com/findadoctor) and select **HMO Blue Select**.

\*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.



# HMO

Accounts with 100+ Eligible Employees  
and Enrolled Subscribers





	Access Blue New England Total Saver	Access Blue New England Enhanced Value	Access Blue New England Basic \$2,000
DEDUCTIBLE <sup>1</sup>	\$3,550/\$7,100	None	Medical: \$2,000/\$4,000 Rx: \$250/\$500
OUT-OF-POCKET MAXIMUM <sup>2</sup>	\$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 <sup>3</sup>	Deductible	\$500	20% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	Deductible	\$250	20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	Deductible	\$50	20% co-insurance 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% co-insurance after Rx deductible
HOSPITAL CHOICE COST SHARING <sup>4</sup>	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% co-insurance SDC: 30% co-insurance Labs: 30% co-insurance X-rays: 30% co-insurance MRI/CT/PET/NC: 30% co-insurance PT/OT/ST: \$75

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT
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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  
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 <sup>1</sup>	\$1,500/\$3,000	\$3,000/\$5,950	\$3,300/\$6,450
OUT-OF-POCKET MAXIMUM <sup>2</sup>	\$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 <sup>3</sup>	Deductible	35% co-insurance after deductible	\$1,000 after deductible
SURGICAL DAY CARE <sup>3</sup>	Deductible	35% co-insurance after deductible	\$1,000 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	Deductible	35% co-insurance 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% co-insurance
HOSPITAL CHOICE COST SHARING <sup>4</sup>	Not Applicable	Not Applicable	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT
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ON THE LAST PAGE

	Blue Choice® New England	Blue Choice® New England Value Plus	Blue Choice® New England Deductible
DEDUCTIBLE <sup>1</sup>	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 <sup>2</sup>	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% co-insurance after deductible	PCP/Plan-Approved: Preventive: \$0 PCP: \$15 Specialist: \$15 Self-Referred: 20% co-insurance after deductible	PCP/Plan-Approved: Preventive: \$0 PCP: \$20 Specialist: \$35 Self-Referred: 20% co-insurance after deductible
EMERGENCY ROOM	\$100	\$100	\$150
INPATIENT ADMISSIONS <sup>3</sup>	PCP/Plan-Approved: \$0 Self-Referred: 20% co-insurance after deductible	PCP/Plan-Approved: \$250 Self-Referred: 20% co-insurance after deductible	PCP/Plan-Approved: Deductible Self-Referred: 20% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	PCP/Plan-Approved: \$0 Self-Referred: 20% co-insurance after deductible	PCP/Plan-Approved: \$150 Self-Referred: 20% co-insurance after deductible	PCP/Plan-Approved: Deductible Self-Referred: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	PCP/Plan-Approved: \$25 Self-Referred: 20% co-insurance after deductible	PCP/Plan-Approved: \$25 Self-Referred: 20% co-insurance after deductible	PCP/Plan-Approved: Deductible Self-Referred: 20% co-insurance 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 <sup>4</sup>	Not Applicable	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 Value Copayment	HMO Blue New England	HMO Blue New England \$500 Deductible
DEDUCTIBLE <sup>1</sup>	None	None	\$500/\$1,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	\$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 <sup>3</sup>	\$1,000	\$0	Deductible
SURGICAL DAY CARE <sup>3</sup>	\$1,000	\$0	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	\$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 <sup>4</sup>	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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ON THE LAST PAGE



	HMO Blue New England \$1,000 Deductible	HMO Blue New England \$1,000 Deductible with Co-insurance	HMO Blue New England \$1,500 Deductible
DEDUCTIBLE <sup>1</sup>	\$1,000/\$2,000	\$1,000/\$2,000	\$1,500/\$3,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible	\$150
INPATIENT ADMISSIONS <sup>3</sup>	Deductible	20% co-insurance after deductible	Deductible
SURGICAL DAY CARE <sup>3</sup>	Deductible	20% co-insurance after deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	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 <sup>4</sup>	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% co-insurance SDC: 30% co-insurance Labs: 30% co-insurance X-rays: 30% co-insurance MRI/CT/PET/NC: 30% co-insurance 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

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ON THE LAST PAGE

	HMO Blue New England \$2,000 Deductible	HMO Blue New England \$3,000 Deductible
DEDUCTIBLE <sup>1</sup>	\$2,000/\$4,000	\$3,000/\$6,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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 <sup>3</sup>	Deductible	Deductible
SURGICAL DAY CARE <sup>3</sup>	Deductible	Deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	Deductible	Deductible
PRESCRIPTION DRUGS	Retail: \$15/\$30/\$50 Mail: \$30/\$60/\$150	Retail: \$15/\$30/\$50 Mail: \$30/\$60/\$150
HOSPITAL CHOICE COST SHARING <sup>4</sup>	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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ON THE LAST PAGE

	HMO Blue New England Deductible II	HMO Blue New England Basic Copayment	HMO Blue New England Basic Co-insurance
DEDUCTIBLE <sup>1</sup>	\$4,000/\$8,000	\$2,000/\$4,000	\$2,000/\$4,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible
INPATIENT ADMISSIONS <sup>3</sup>	Deductible	\$1,000 after deductible	35% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	Deductible	\$1,000 after deductible	35% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	Deductible	\$1,000 after deductible	35% co-insurance 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 and 3: Retail and Mail: 50% co-insurance
HOSPITAL CHOICE COST SHARING <sup>4</sup>	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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	HMO Blue New England Options v.5 <sup>5</sup>	HMO Blue New England Options Deductible v.5 <sup>5</sup>	HMO Blue New England Options Deductible II v.5 <sup>5</sup>
DEDUCTIBLE <sup>1</sup>	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 <sup>2</sup>	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 <sup>3</sup>	EBT: \$250 SBT: \$500 (\$300 for select hospitals) <sup>6</sup> BBT: \$1,000	EBT: \$150 SBT: \$150 after deductible (\$200 for select hospitals) <sup>6</sup> BBT: \$1,000 after deductible	EBT: \$250 SBT: \$250 after deductible (\$300 for select hospitals) <sup>6</sup> BBT: \$1,500 after deductible
SURGICAL DAY CARE <sup>3</sup>	EBT: \$150 SBT: \$250 BBT: \$500	EBT: \$150 SBT: \$150 after deductible (\$200 for select hospitals) <sup>6</sup> BBT: \$1,000 after deductible	EBT: \$250 SBT: \$250 after deductible (\$300 for select hospitals) <sup>6</sup> BBT: \$1,500 after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	EBT: \$75 SBT: \$150 BBT: \$250 Other Network Provider: \$75	EBT: \$50 SBT: \$50 after deductible (\$50 for select hospitals) <sup>6</sup> BBT: \$450 after deductible Other Network Provider: \$50	EBT: \$75 SBT: \$75 after deductible (\$75 for select hospitals) <sup>6</sup> 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 <sup>4</sup>	Not Applicable	Not Applicable	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT
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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  
ON THE LAST PAGE



	HMO Blue New England Options Deductible III v.5 <sup>5</sup>	HMO Blue New England Value	HMO Blue New England Value Plus
DEDUCTIBLE <sup>1</sup>	\$2,000/\$4,000	None	None
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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 <sup>3</sup>	EBT: Deductible SBT: \$500 after deductible (\$50 after deductible for select hospitals) <sup>6</sup> BBT: \$1,500 after deductible	\$500	\$250
SURGICAL DAY CARE <sup>3</sup>	EBT: Deductible SBT: \$500 after deductible (\$50 after deductible for select hospitals) <sup>6</sup> BBT: \$1,500 after deductible	\$250	\$150
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	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 <sup>4</sup>	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
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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  
ON THE LAST PAGE

	HMO Blue New England Enhanced Value	HMO Blue New England Premier Value	HMO Blue New England Premier Value with Co-insurance
DEDUCTIBLE <sup>1</sup>	None	Inpatient: \$1,000/\$2,500	Inpatient: \$1,000/\$2,500
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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 <sup>3</sup>	\$500	Deductible	Deductible
SURGICAL DAY CARE <sup>3</sup>	\$250	\$250	35% co-insurance
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	\$50	\$75	35% co-insurance
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 <sup>4</sup>	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% co-insurance Labs: 50% co-insurance X-rays: 50% co-insurance MRI/CT/PET/NC: 50% co-insurance PT/OT/ST: \$75

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT
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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  
ON THE LAST PAGE

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

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS	BLUE SELECT
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# PPO

Accounts with 100+ Eligible Employees  
and Enrolled Subscribers





	Blue Care Elect Value Copayment	Blue Care Elect Preferred	Blue Care Elect Preferred 90 with Copayment
DEDUCTIBLE <sup>1</sup>	IN: None OON: \$500/\$1,000	IN: None OON: \$250/\$500	IN and OON combined: \$250/\$500
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$15 Specialist: \$15 OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$15 Specialist: \$15 OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$1,000	\$100	\$150
INPATIENT ADMISSIONS <sup>3</sup>	IN: \$1,000 OON: 20% co-insurance after deductible	IN: \$0 OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 30% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: \$1,000 OON: 20% co-insurance after deductible	IN: \$0 OON: 20% co-insurance after deductible	IN: \$250 after deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: \$1,000 OON: 20% co-insurance after deductible	IN: \$25 OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 30% co-insurance 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 <sup>4</sup>	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% co-insurance SDC: \$1,250 Labs: 20% co-insurance X-rays: 20% co-insurance MRI/CT/PET/NC: 20% co-insurance 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 VBB: Value-Based Benefits OON: Out-of-Network

**FOOTNOTES LOCATED  
ON THE LAST PAGE**

	Blue Care Elect Preferred 90	Blue Care Elect Preferred 80 wih Copayment	Blue Care Elect Preferred 80
DEDUCTIBLE <sup>1</sup>	IN and OON combined: \$250/\$500	IN and OON combined: \$500/\$1,000	IN and OON combined: \$500/\$1,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible Specialist: 10% co-insurance after deductible OON: 30% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$20 Specialist: \$20 OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: 20% co-insurance after deductible Specialist: 20% co-insurance after deductible OON: 40% co-insurance after deductible
EMERGENCY ROOM	10% co-insurance after deductible	\$150	20% co-insurance after deductible
INPATIENT ADMISSIONS <sup>3</sup>	IN: 10% co-insurance after deductible OON: 30% co-insurance after deductible	IN: 20% co-insurance after deductible OON: 40% co-insurance after deductible	IN: 20% co-insurance after deductible OON: 40% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: 10% co-insurance after deductible OON: 30% co-insurance after deductible	IN: \$250 after deductible OON: 20% co-insurance after deductible	IN: 20% co-insurance after deductible OON: 40% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: 10% co-insurance after deductible OON: 30% co-insurance after deductible	IN: 20% co-insurance after deductible OON: 40% co-insurance after deductible	IN: 20% co-insurance after deductible OON: 40% co-insurance 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 <sup>4</sup>	After deductible Inpatient: 20% co-insurance SDC: 20% co-insurance Labs: 20% co-insurance X-rays: 20% co-insurance MRI/CT/PET/NC: 20% co-insurance PT/OT/ST: 20% co-insurance	After deductible Inpatient: 30% co-insurance SDC: \$1,250 Labs: 30% co-insurance X-rays: 30% co-insurance MRI/CT/PET/NC: 30% co-insurance PT/OT/ST: \$55 (no deductible)	After deductible Inpatient: 30% co-insurance SDC: 30% co-insurance Labs: 30% co-insurance X-rays: 30% co-insurance MRI/CT/PET/NC: 30% co-insurance PT/OT/ST: 30% co-insurance

**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 VBB: Value-Based Benefits OON: Out-of-Network

**FOOTNOTES LOCATED  
ON THE LAST PAGE**

	Blue Care Elect Value Plus	Blue Care Elect Enhanced Value	Blue Care Elect \$1,000 Deductible
DEDUCTIBLE <sup>1</sup>	IN: None OON: \$500/\$1,000	IN: None OON: \$500/\$1,000	IN and OON combined: \$1,000/\$2,500
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$20 Specialist: \$20 OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$100	\$150	\$150 after deductible
INPATIENT ADMISSIONS <sup>3</sup>	IN: \$250 OON: 20% co-insurance after deductible	IN: \$500 OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: \$150 OON: 20% co-insurance after deductible	IN: \$250 OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: \$25 OON: 20% co-insurance after deductible	IN: \$50 OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance 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 <sup>4</sup>	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 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**

	Blue Care Elect \$1,500 Deductible	Blue Care Elect \$2,000 Deductible	Blue Care Elect \$3,000 Deductible
DEDUCTIBLE <sup>1</sup>	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 <sup>2</sup>	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% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$150 after deductible	\$150 after deductible	\$150 after deductible
INPATIENT ADMISSIONS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance 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 <sup>4</sup>	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
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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  
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 <sup>1</sup>	IN and OON combined: \$4,500/\$9,000	IN and OON combined: \$1,500/\$3,000	IN and OON combined: \$1,500/\$3,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: 10% co-insurance after deductible Specialist: 10% co-insurance after deductible OON: 30% co-insurance after deductible (20% co-insurance for preventive care)
EMERGENCY ROOM	\$150 after deductible	\$150 after deductible	\$150 after deductible
INPATIENT ADMISSIONS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 30% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 30% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: 10% co-insurance after deductible OON: 30% co-insurance 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 <sup>4</sup>	Not Applicable	Not Applicable	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS
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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  
ON THE LAST PAGE

	Blue Care Elect Saver \$2,700 (HSA Compliant)	Preferred Blue® PPO Value Copayment	Preferred Blue® PPO 80 with Copayment
DEDUCTIBLE <sup>1</sup>	IN and OON combined: \$2,700/\$5,400	IN: None OON: \$500/\$1,000	IN and OON combined: \$500/\$1,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: \$75 Specialist: \$100 OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$20 Specialist: \$20 OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$150 after deductible	\$1,000	\$150
INPATIENT ADMISSIONS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: \$1,000 OON: 20% co-insurance after deductible	IN: 20% co-insurance after deductible OON: 40% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: \$1,000 OON: 20% co-insurance after deductible	IN: \$250 after deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: \$1,000 OON: 20% co-insurance after deductible	IN: 20% co-insurance after deductible OON: 40% co-insurance 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 <sup>4</sup>	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% co-insurance SDC: \$1,250 Labs: 30% co-insurance X-rays: 30% co-insurance MRI/CT/PET/NC: 30% co-insurance PT/OT/ST: \$55 (no deductible)

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS
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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  
ON THE LAST PAGE



	Preferred Blue® PPO \$1,000 Deductible	Preferred Blue® PPO \$2,000 Deductible	Preferred Blue® PPO Deductible II
DEDUCTIBLE <sup>1</sup>	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 <sup>2</sup>	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% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$25 after deductible Specialist: \$40 after deductible OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$150 after deductible	\$150 after deductible	Deductible
INPATIENT ADMISSIONS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance 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 <sup>4</sup>	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
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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  
ON THE LAST PAGE

	Preferred Blue® PPO Basic \$2,000	Preferred Blue® PPO Basic Copayment	Preferred Blue® PPO Basic Co-insurance
DEDUCTIBLE <sup>1</sup>	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 <sup>2</sup>	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% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$65 Specialist: \$65 OON: 20% co-insurance after deductible	IN: Preventive: \$0 Primary Care: \$60 Specialist: \$60 OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$250	\$750 after in-network deductible	35% co-insurance after in-network deductible
INPATIENT ADMISSIONS <sup>3</sup>	IN: 20% co-insurance after deductible OON: 40% co-insurance after deductible	IN: \$1,000 after deductible OON: 20% co-insurance after deductible	IN: 35% co-insurance after deductible OON: 55% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: 20% co-insurance after deductible OON: 40% co-insurance after deductible	IN: \$1,000 after deductible OON: 20% co-insurance after deductible	IN: 35% co-insurance after deductible OON: 55% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: 20% co-insurance after deductible OON: 40% co-insurance after deductible	IN: \$1,000 after deductible OON: 20% co-insurance after deductible	IN: 35% co-insurance after deductible OON: 55% co-insurance after deductible
PRESCRIPTION DRUGS	IN: Retail: \$15/50% co-insurance/50% co-insurance Mail: \$30/50% co-insurance/50% co-insurance OON: \$30/50% co-insurance/50% co-insurance Mail: Not covered	IN: Retail: \$15/50% co-insurance/50% co-insurance Mail: \$30/50% co-insurance/50% co-insurance OON: \$30/50% co-insurance/50% co-insurance Mail: Not covered	IN: Retail: \$15/50% co-insurance/50% co-insurance Mail: \$30/50% co-insurance/50% co-insurance OON: \$30/50% co-insurance/50% co-insurance Mail: Not covered
HOSPITAL CHOICE COST SHARING <sup>4</sup>	After deductible Inpatient: 30% co-insurance SDC: 30% co-insurance Labs: 30% co-insurance X-rays: 30% co-insurance MRI/CT/PET/NC: 30% co-insurance 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 VBB: Value-Based Benefits OON: Out-of-Network

**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 <sup>1</sup>	IN and OON combined: \$1,500/\$3,000	IN and OON combined: \$2,000/\$4,000	IN and OON combined: \$2,900/\$5,800
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: Deductible Specialist: Deductible OON: 20% co-insurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: Deductible Specialist: Deductible OON: 20% co-insurance after deductible (no deductible for preventive care)
EMERGENCY ROOM	\$150 after deductible	\$150 after deductible	\$150 after deductible
INPATIENT ADMISSIONS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance 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 <sup>4</sup>	Not Applicable	Not Applicable	Not Applicable

LEGEND:	HOSPITAL CHOICE COST SHARING	BLUE OPTIONS
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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  
ON THE LAST PAGE

	Preferred Blue® PPO Basic Saver (HSA Compliant)	Preferred Blue® PPO Saver II (HSA Compliant)	Preferred Blue® PPO Options v.5 <sup>5</sup>
DEDUCTIBLE <sup>1</sup>	IN: \$3,300/\$6,450 OON: \$6,300/\$10,000	IN and OON combined: \$4,000/\$8,000	IN: None OON: \$2,000/\$4,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	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% co-insurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: \$25 after deductible Specialist: \$40 after deductible OON: 20% co-insurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 EBT: \$15 SBT: \$25 BBT: \$45 Other Network Provider: \$45 OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$750 after in-network deductible	Deductible	\$150
INPATIENT ADMISSIONS <sup>3</sup>	IN: \$1,000 after deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: EBT: \$250 SBT: \$500 (\$300 for select hospitals) <sup>5</sup> BBT: \$1,000 OON: 20% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: \$1,000 after deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: EBT: \$150 SBT: \$250 BBT: \$500 OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: \$1,000 after deductible OON: 20% co-insurance after deductible	IN: Deductible OON: 20% co-insurance after deductible	IN: EBT: \$75 SBT: \$150 BBT: \$250 Other Network Provider: \$75 OON: 20% co-insurance after deductible
PRESCRIPTION DRUGS	After deductible IN: Retail: \$15/50% co-insurance/50% co-insurance Mail: \$30/50% co-insurance/ 50% co-insurance OON: \$30/50% co-insurance/ 50% co-insurance 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 <sup>4</sup>	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 VBB: Value-Based Benefits OON: Out-of-Network

**FOOTNOTES LOCATED  
ON THE LAST PAGE**

	Preferred Blue® PPO Options Deductible II v.5 <sup>5</sup>	Preferred Blue® PPO Options Deductible III v.5 <sup>5</sup>
DEDUCTIBLE <sup>1</sup>	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 <sup>2</sup>	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% co-insurance after deductible	IN: Preventive: \$0 EBT: \$20 SBT: \$35 BBT: \$55 Other Network Provider: \$55 OON: 20% co-insurance after deductible
EMERGENCY ROOM	\$250	\$250
INPATIENT ADMISSIONS <sup>3</sup>	IN: EBT: \$500 SBT: \$500 after deductible (\$550 for select hospitals) <sup>6</sup> BBT: \$1,500 after deductible OON: 20% co-insurance after deductible	IN: EBT: Deductible SBT: \$500 after deductible (\$50 after deductible for select hospitals) <sup>6</sup> BBT: \$1,500 after deductible OON: 20% co-insurance after deductible
SURGICAL DAY CARE <sup>3</sup>	IN: EBT: \$500 SBT: \$500 after deductible (\$550 for select hospitals) <sup>6</sup> BBT: \$1,500 after deductible OON: 20% co-insurance after deductible	IN: EBT: Deductible SBT: \$500 after deductible (\$50 after deductible for select hospitals) <sup>6</sup> BBT: \$1,500 after deductible OON: 20% co-insurance after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	IN: EBT: \$75 SBT: \$75 after deductible BBT: \$450 after deductible Other Network Provider: \$75 OON: 20% co-insurance after deductible	IN: EBT: Deductible SBT: \$75 after deductible BBT: \$450 after deductible Other Network Provider: \$0 OON: 20% co-insurance 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 <sup>4</sup>	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 VBB: Value-Based Benefits OON: Out-of-Network

**FOOTNOTES LOCATED  
ON THE LAST PAGE**

# EPO

Accounts with 100+ Eligible Employees  
and Enrolled Subscribers





	NEW FOR 2023 Advantage Blue® Preferred	NEW FOR 2023 Advantage Blue® Preferred Deductible	NEW FOR 2023 Advantage Blue® Preferred Saver
DEDUCTIBLE <sup>1</sup>	None	\$1,500/\$3,000	\$2,000/\$4,000
OUT-OF-POCKET MAXIMUM <sup>2</sup>	Medical: \$5,490/\$10,900 Rx: \$1,000/\$2,000	Medical: \$5,490/\$10,900 Rx: \$1,000/\$2,000	\$6,750/\$13,500 (but no more than \$6,750 per member)
OFFICE VISIT	Preventive: \$0 PCP: \$15 Specialist: \$15	Preventive: \$0 PCP: \$15 after deductible Specialist: \$15 after deductible	Preventive: \$0 PCP: \$15 after deductible Specialist: \$15 after deductible
EMERGENCY ROOM	\$150	No cost after deductible	No cost after deductible
INPATIENT ADMISSIONS <sup>3</sup>	\$500	No cost after deductible	No cost after deductible
SURGICAL DAY CARE <sup>3</sup>	\$250	No cost after deductible	No cost after deductible
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS <sup>3</sup>	\$75	No cost after deductible	No cost after deductible
PRESCRIPTION DRUGS	Retail: \$10/\$25/\$45 Mail: \$20/\$50/\$90	Retail: \$15/\$30/\$50 Mail: \$30/\$60/\$100	Retail: \$10/\$25/\$45 after deductible Mail: \$20/\$50/\$90 after deductible

## MEDICARE CREDITABLE COVERAGE

All plans in this brochure meet Medicare Creditable Coverage prescription drug coverage requirements. 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 brochure meet the minimum level of benefits for adult tax filers to be considered insured and avoid tax penalties in Massachusetts.

## 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, co-insurance, and deductible, including costs for covered prescription drugs.
3. This is the cost sharing for services rendered at hospitals other than those that are designated as higher cost.
4. 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.
5. Outside Massachusetts, the lower Enhanced Benefits Tier copayment applies to any network provider that is listed as a general practitioner, pediatrician, obstetrician/gynecologist, nurse practitioner, rural health center, limited service 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.
6. 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.



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