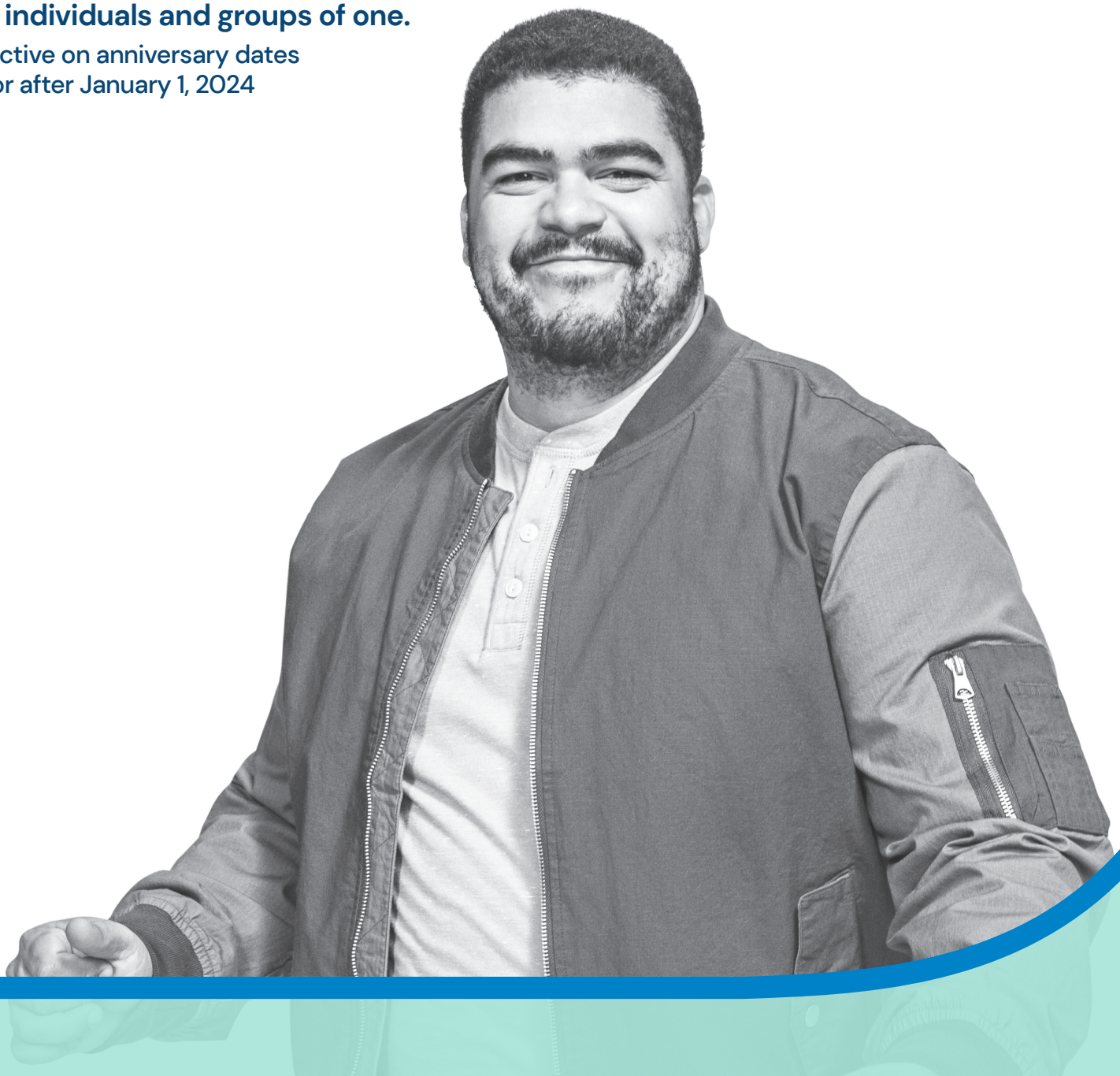
MASSACHUSETTS

BENEFITS AND COVERAGE
UPDATES FOR 2024

GETTING MORE. NOW THERE'S A PLAN.

For individuals and groups of one.

Effective on anniversary dates
on or after January 1, 2024



Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

FEDERAL MANDATES AND OTHER CHANGES

COST-SHARE CHANGES FOR 2024

Changes to cost-sharing amounts are due to a variety of factors, such as needing to meet the requirements set by the Affordable Care Act (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.

ACA OUT-OF-POCKET MAXIMUM AND IRS COST-OF-LIVING ADJUSTMENTS FOR 2024

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 guidelines for HSA-compatible, high-deductible plans.

$0 LIMITED SERVICES CLINIC

To increase convenient access to low-cost, high-quality care, this benefit allows members to visit limited service clinics at no cost. Limited service clinics, like CVS Minute Clinic®℠, are typically staffed by nurse practitioners and are located within retail settings and 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.

ANNUAL OUT-OF-POCKET MAXIMUMS FOR 2024

Plan type	Individual coverage	Family coverage
HSA-QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS	$8,050	$16,100
NON-HSA-QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS	$9,450	$18,900

MINIMUM DEDUCTIBLE AMOUNTS FOR 2024

Plan type	Individual coverage	Family coverage
HSA-QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS	$1,600	$3,200

DO MORE WITH MYBLUE

- VIEW PLAN AND COVERAGE DETAILS
- FIND IN-NETWORK DOCTORS
- TRACK AND MANAGE CLAIMS
- CHECK DEDUCTIBLE BALANCES
- ACCESS MEMBER ID CARDS

THE BEST HEALTH INSURANCE IS THE KIND YOU UNDERSTAND

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 choose **HMO Blue Select**.

HMO

Individuals and groups of one

	HMO Blue Premium	HMO Blue Copayment	HMO Blue Deductible with Copayment
DEDUCTIBLE	None	None	Medical: $2,000/$4,000 per plan year[4] Rx: $250/$500 (Tiers 2 and 3)
OUT-OF-POCKET MAXIMUM	$2,650/$5,300 per plan year (includes Rx)[2]	$5,650/$11,300 per plan year (includes Rx)[2]	$5,250/$10,500 per plan year (includes Rx)[2]
OFFICE VISIT	Preventive - None PCP - $20 Specialist - $40	Preventive: None PCP - $30 Specialist - $55	Preventive - None PCP - $30 Specialist - $55
EMERGENCY ROOM	$150	$350	$350 after Ded.
INPATIENT ADMISSIONS	$500	$750	$750 after Ded.
SURGICAL DAY CARE	$250	$500	$500 after Ded.
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS	$150	$250	$300 after Ded.
PRESCRIPTION DRUGS	Retail: $10/$25/$50 Mail: $20/$50/$150 Mail Order with Retail Choice Program	Retail: $30/$60/$90 Mail: $60/$120/$270 Mail Order with Retail Choice Program	Retail: $25/$50 after Rx Ded./ $100 after Rx Ded. Mail: $50/$100 after Rx Ded./ $300 after Rx Ded. Mail Order with Retail Choice Program
HOSPITAL CHOICE COST SHARING	Not Applicable	Not Applicable	Not Applicable

	HMO Blue Basic	HMO Blue Select $1,000 Deductible with Copayment	HMO Blue Select $2,000 Deductible
DEDUCTIBLE	$2,000/$4,000 per plan year (includes medical & Rx tier 3)[4]	$1,000/$2,000 per plan year[4]	$2,000/$4,000 per plan year[4]
OUT-OF-POCKET MAXIMUM	$9,100/$18,200 (includes Rx)[2]	$6,950/$13,900 per plan year (includes Rx)[2]	$8,750/$17,500 per plan year (includes Rx)[2]
OFFICE VISIT	Preventive - None PCP - $25 Specialist - $60	Preventive - None PCP - $25[10b] Specialist - $55[10b]	Preventive - None PCP - $25[10b] Specialist - $50[10b]
EMERGENCY ROOM	$350 after Ded.	$350	$500
INPATIENT ADMISSIONS	$1,000 after Ded.	$750 after Ded.	$250 after Ded.
SURGICAL DAY CARE	$500 after Ded.	$500 after Ded.	Ded.
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS	$350 after Ded.	$250 after Ded.	$250 after Ded.
PRESCRIPTION DRUGS	Retail: $30/$55/$75 after Ded. Mail: $60/$110/$225 after Ded. Mail Order with Retail Choice Program	Retail[21]: $10/$45/$80/$225/50% with $350 Max/50% with $500 Max Mail[21]: $20/$90/$160/$675 Mail Order with Retail Choice Program	Retail[21]: $10/$45/$150/$225/50% with $350 Max/50% with $500 Max Mail[21]: $20/$90/$300/$675 Mail Order with Retail Choice Program
HOSPITAL CHOICE COST SHARING	Not Applicable	Not Applicable	Not Applicable

LEGEND: BLUE SELECT

KEY: 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 Saver	HMO Blue Select $3,000 Deductible	HMO Blue Basic Deductible
DEDUCTIBLE	$2,000/$4,000 per plan year (includes Rx)[4, 8]	$3,000/$6,000 per plan year[4]	$2,850/$5,700 per plan year[4] (includes medical & Rx tiers 2 and 3)
OUT-OF-POCKET MAXIMUM	$6,700/$13,400 (includes Rx)[2]	$9,100/$18,200 per plan year (includes Rx)[2]	$9,100/$18,200 per plan year (includes Rx)[2]
OFFICE VISIT	Preventive - None PCP - $30 after Ded. Specialist - $60 after Ded.	Preventive - None PCP - $40[10b] Specialist - $65[10b]	Preventive - None PCP - $30 after Ded. Specialist - $65 after Ded.
EMERGENCY ROOM	$300 after Ded.	$750 after Ded.	$400 after Ded.
INPATIENT ADMISSIONS	$750 after Ded.	$1,000 after Ded.	$1,000 after Ded.
SURGICAL DAY CARE	$500 after Ded.	$750 after Ded.	$500 after Ded.
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS	$500 after Ded.	$500 after Ded.	$350 after Ded.
PRESCRIPTION DRUGS	After Ded.[17] Retail: $30/$60/$105 Mail: $60/$120/$315 Mail Order with Retail Choice Program	Retail[21]: $10/$45/$175/$225/50% with $350 Max/50% with $500 Max Mail[21]: $20/$90/$350/$675 Mail Order with Retail Choice Program	Retail: $30/$65 after Ded./$100 after Ded. Mail: $60/$130 after Ded./$300 after Ded. Mail Order with Retail Choice Program
HOSPITAL CHOICE COST SHARING	Not Applicable	Not Applicable	Not Applicable

LEGEND: BLUE SELECT

KEY: SDC: Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy **VBB** Value-Based Benefits
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FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue Select $2,000 Deductible with Copayment	HMO Blue Select Saver $2,000	HMO Blue Essential
DEDUCTIBLE	$2,000/$4,000 per plan year[4]	$2,000/$4,000 per plan year (includes Rx)[4, 8]	$9,100/$18,200 per calendar year (includes Rx)[4]
OUT-OF-POCKET MAXIMUM	$9,100/$18,200 per plan year (includes Rx)[2]	$7,150/$14,300 per plan year (includes Rx)[2]	$9,100/$18,200 per calendar year (includes Rx)[2]
OFFICE VISIT	Preventive - None PCP - $30[10b] Specialist - $60[10b]	Preventive - None PCP - $35 after Ded.[10b] Specialist - $65 after Ded.[10b]	Preventive - None PCP - Ded.[16] Specialist - Ded.
EMERGENCY ROOM	$850 after Ded.	$250 after Ded.	Ded.
INPATIENT ADMISSIONS	$750 after Ded.	$750 after Ded.	Ded.
SURGICAL DAY CARE	$500 after Ded.	$500 after Ded.	Ded.
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS	$750 after Ded.	$350 after Ded.	Ded.
PRESCRIPTION DRUGS	Retail[21]: $10/$45/$225/$275/50% with $350 Max/50% with $500 Max Mail[21]: $20/$90/$450/$825 Mail Order with Retail Choice Program	After Ded.[17] Retail[21]: $10/$45/$175/$250/50% with $350 Max/50% with $500 Max Mail[21]: $20/$90/$350/$750 Mail Order with Retail Choice Program	Ded. Mail Order with Retail Choice Program
HOSPITAL CHOICE COST SHARING	Not Applicable	Not Applicable	Not Applicable

PPO

Individuals and groups of one

	Preferred Blue® PPO Saver with Copayment
DEDUCTIBLE	IN: $2,000/$4,000 per plan year (includes Rx)[4, 8] OON: $5,000/$10,000 per plan year (includes Rx)[8]
OUT-OF-POCKET MAXIMUM	IN: $6,700/$13,400 (includes Rx)[2] OON: $13,400/$26,800 (includes Rx)[2]
OFFICE VISIT	Preventive - IN: None OON: 20% Coins. Medical - IN: PCP - $30 after Ded. Specialist -$60 after Ded. OON: 20% Coins. after Ded.
EMERGENCY ROOM	$300 after In-Network Ded.
INPATIENT ADMISSIONS	IN: $750 after Ded. OON: 20% Coins. after Ded.
SURGICAL DAY CARE	IN: $500 after Ded. OON: 20% Coins. after Ded.
MRI, CT, PET SCANS, AND NUCLEAR CARDIAC IMAGING TESTS	IN: $500 after Ded. OON: 20% Coins. after Ded.
PRESCRIPTION DRUGS	After in-network Ded[17]: IN: Retail: $30/$60/$105 Mail: $60/120/$315 Mail Order with Retail Choice Program After out-of-network Ded[17]: OON: Retail: $60/$120/$210 Mail: Not covered
HOSPITAL CHOICE COST SHARING	Not Applicable

KEY: 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

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† that adult tax filers need to be considered insured and avoid tax penalties in Massachusetts.

†Medicare Creditable Coverage and Minimum Creditable Coverage don't apply to the HMO Blue Essential plan.

FOOTNOTES

1. This is the cost sharing for services rendered at hospitals other than those that are designated as higher cost.
2. The two out-of-pocket maximum amounts refer to individual and family.

3a. View a list of HCCS hospitals and clinics and their cost share:
https://home.bluecrossma.com/collateral/sites/g/files/csphws1571/files/acquiadam-assets/55-1508_HCCS_Hospital_List.pdf

4. The two deductible amounts refer to individual and family.
8. Entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.

10b. Members will pay nothing for the first two diabetic monitoring visits per calendar year. These are services such as diabetic evaluation and management services, including diabetic eye exams and foot care.

15. 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 member deductible.
16. No charge after deductible, except $35 copayment per visit or 50% co-insurance (no deductible) for the first three visits per member per calendar year.
17. Overall deductible does not apply to preventive care or preventive drugs defined by the ACA.
20. Network providers who are designated as a Virtual Primary Care Provider ("VPCP") as part of a Virtual Care Team. A Virtual Care Team is a model that includes primary care with integrated mental health and/or substance use support delivered virtually by a Primary Care Provider as part of a patient care team. The Virtual Care Model includes a care coordinator to assist in managing care with a Virtual Care Team or other in-network specialist (virtually or in person) as well as exchange any necessary medical records when possible.

Questions?

If you have any questions, call Member Service at the number on your ID card (TTY: **711**).

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