BlueCross® BlueShield®

SUMMARY OF BENEFITS

HMO BLUE NEW ENGLAND BASIC SAVER

Plan-Year Deductible: $3,350/$6,550
Effective on anniversary dates on or after January 1, 2023
for Individuals and Small Groups

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

Download the app, or create an account at **bluecrossma.org.**

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CARE

Your Primary Care Provider (PCP)
When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**; consult Find a Doctor at **bluecrossma.com/findadoctor**; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school the doctor attended, and whether there are languages other than English spoken in the office.

Referrals
Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see an HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your subscriber certificate.

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$3,350** per member (or **$6,550** per family). **No one member will have to pay more than the per member deductible.**

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is **$6,450** per member (or **$12,900** per family).

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team
Your health plan includes the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **After meeting your deductible, for outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your subscriber certificate, or call the Member Service number on your ID card.

Service Area
The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area
If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your subscriber certificate for more information.

Dependent Benefits
This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your subscriber certificate (and riders, if any) for exact coverage details.

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $2,000 per ear every 36 months)	All charges beyond the maximum after deductible
Routine vision exams (one every 24 months, except one every 12 months until the end of the month a member turns age 19)	Nothing, no deductible
Vision supplies (one set of prescription lenses and/or frames or contact lenses per calendar year until the end of the month a member turns age 19)	35% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	$1,500 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$45 per visit after deductible $75 per visit after deductible
Mental health or substance use treatment	$45 per visit after deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit $45 per visit after deductible
Diabetic management services (first two visits per calendar year*)	Nothing, no deductible
Chiropractors' office visits	$75 per visit after deductible
Acupuncture visits (up to 12 visits per calendar year)	$75 per visit after deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits for rehabilitation services and 60 visits for habilitation services per calendar year**)	$85 per visit after deductible
Speech, hearing, and language disorder treatment—speech therapy	$85 per visit after deductible
Diagnostic X-rays • At a general hospital • By other covered providers	$125 per service date after deductible*** Nothing after deductible
Diagnostic lab tests • At a general hospital • By other covered providers	$80 per service date after deductible*** Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests • At a general hospital • By other covered providers	$1,000 per category per service date after deductible*** $750 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible†
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$45 per visit†† after deductible $75 per visit†† after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$1,000 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	$1,500 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$1,500 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	$1,500 per admission after deductible
Skilled nursing facility care (up to 100 days per calendar year)	$1,500 per admission after deductible

* These diabetic services are for diabetes evaluation and management services, diabetic eye exams, or diabetic foot care.
** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
*** Some general hospitals may provide services at off-site locations (satellite locations). Services at these satellite locations will apply the higher cost share.
† Cost share waived for one breast pump per birth, including supplies.
†† Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated non-specialty retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	$10 after deductible for Tier 1*** $45 after deductible for Tier 2*** $175 after deductible for Tier 3† $250 after deductible for Tier 4†
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)**	$20 after deductible for Tier 1*** $90 after deductible for Tier 2*** $350 after deductible for Tier 3† $750 after deductible for Tier 4†
Specialty drugs when obtained from a designated specialty pharmacy (up to a 30-day formulary supply for each prescription or refill)	$10 after deductible for Tier 1 $45 after deductible for Tier 2 50% coinsurance after deductible for Tier 5 (maximum of $350)† 50% coinsurance after deductible for Tier 6 (maximum of $500)†

* Generally, Tier 1 refers to preferred generic drugs; Tier 2 refers to non-preferred generic drugs; Tier 3 refers to preferred brand-name drugs; Tier 4 refers to non-preferred brand-name drugs; Tier 5 refers to preferred brand-name specialty drugs; Tier 6 refers to non-preferred brand-name specialty drugs. Your pharmacy coverage includes the Mail Order with Retail Choice Program that requires you to take action. For a complete description of the program refer to your subscriber certificate and riders. To find out which maintenance drugs are part of the program, call the Member Service number on your ID card, or visit our website at bluecrossma.org/90daymeds.

** Cost share may be waived for certain covered drugs and supplies. Retail drugs are available in a 90-day supply at three times the standard retail cost share.

*** Cost share waived for select generic drugs that treat depression, cholesterol, diabetes, heart, and high blood pressure. For a list of these drugs, contact Blue Cross Blue Shield of Massachusetts or visit bluecrossma.org/medication.

† If you choose to buy a brand-name drug where allowed by state law, instead of a generic drug equivalent (if available), your out-of-pocket costs will be more. For these covered brand-name drugs, your cost share will include the generic drug cost share as well as all costs that are in excess of the allowed charge for the generic drug equivalent. All costs that you pay for these covered drugs will count toward your out-of-pocket maximum.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-262-BLUE (2583) to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your subscriber certificate for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your subscriber certificate for details.)	$150 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-262-BLUE (2583), or visit us online at bluecrossma.org. Interested in our Medicare Plans? Visit bluecrossma.com/medicare.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.

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MASSACHUSETTS

PEDIATRIC ESSENTIAL DENTAL BENEFITS

Your health plan coverage includes a dental policy that covers pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

This separate dental policy covers pediatric essential dental benefits for members until the end of the calendar month in which they turn age 19 as required by federal law.

You must meet a plan-year deductible for certain covered dental services. Your deductible is **$50** per member (no more than **$150** for three or more members enrolled under the same family membership).

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and coinsurance for covered dental services. Your out-of-pocket maximum is **$350** per member (no more than **$700** for two or more members enrolled under the same family membership).

To find participating dental providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com/findadoctor** or call the Member Service number on your ID card.

Pediatric Essential Dental Benefits*	Your Cost In-Network**
Group 1: Preventive and Diagnostic Services: oral exams, X-rays, and routine dental care	Nothing, no deductible
Group 2: Basic Restorative Services: fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance	25% coinsurance after deductible
Group 3: Major Restorative Services: tooth replacement, resin crowns, and occlusal guards	50% coinsurance after deductible
Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member	50% coinsurance, no deductible

* All covered services are limited to members until the end of the month they turn age 19, and may be subject to an age-based schedule or frequency. For a complete list of covered services or additional information, refer to your subscriber certificate.

** There are no out-of-network benefits for dental services.

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

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PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíiji̧' béésh bee hodíílnih (TTY: **711**).

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