BlueCross® BlueShield®

SUMMARY OF BENEFITS

Blue Care® Elect Preferred 80

with Copay and Hospital Choice Cost Sharing

Winn Management Group

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the preferred general hospitals listed in this Summary of Benefits, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital (not listed in this Summary of Benefits) for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.com/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

MyBlue is a personalized way to access and manage your health plan. Get secure access to key plan information, claims history, and recent medications. Download or email a copy of your digital ID card. View your spending dashboard, important updates, alerts and notifications. Register or log in at bluecrossma.com/myblue or download the app on iTunes® or Google Play™.

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 Choice

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each calendar year before you can receive coverage for most benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductibles are **$1,250** per member (or **$2,500** per family) for in-network services and **$3,750** per member (or **$7,500** per family) for out-of-network services. Any amount applied toward the in-network deductible will also be applied toward the out-of-network deductible (and vice versa).

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your "in-network" benefits. See the charts for your cost share.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive certain services at or by "higher cost share hospitals," including inpatient admissions, outpatient day surgery, and some other hospital outpatient services.

Note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level–even if the preferred provider refers you. It is also important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your preferred provider refers you.

Higher Cost Share Hospitals

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- UMass Memorial Medical Center

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply.

How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com/findadoctor**

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits. See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your subscriber certificate. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximums are **$3,000** per member (or **$6,000** per family) for in-network services and **$6,000** per member (or **$12,000** per family) for out-of-network services. Any amount applied toward the in-network out-of-pocket maximum will also be applied toward the out-of-network out-of-pocket maximum (and vice versa).

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). You pay a copayment per visit for in-network or out-of-network 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

You are covered for certain medical and mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at **wellconnection.com** on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com**, consult the Provider Directory, or call the Member Service number on your ID card.

Utilization Review Requirements

Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your subscriber certificate for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

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.

Your Medical Benefits

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care Well-child care exams, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including related tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services–office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care Emergency room visits	$200 per visit, no deductible (waived if admitted or for observation stay)	$200 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, multi-specialty provider group, 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	$25 per visit, no deductible $40 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Mental health or substance use treatment	$25 per visit, no deductible	20% coinsurance after deductible
Telehealth services for simple medical conditions or mental health	$25 per visit, no deductible	20% coinsurance after deductible
Chiropractors' office visits	$40 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calenday year)	$40 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*) • At other hospitals or by other covered providers • At or by higher cost share hospitals	 $40 per visit, no deductible $75 per visit, no deductible	 20% coinsurance after deductible 20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy • At other hospitals or by other covered providers • At or by higher cost share hospitals	 $40 per visit, no deductible $75 per visit, no deductible	 20% coinsurance after deductible 20% coinsurance after deductible
Diagnostic X-rays and lab tests • At other hospitals or by other covered providers • At or by higher cost share hospitals	 20% coinsurance after deductible 30% coinsurance after deductible	 40% coinsurance after deductible 40% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests • At other hospitals or by other covered providers • At or by higher cost share hospitals	 20% coinsurance after deductible 30% coinsurance after deductible	 40% coinsurance after deductible 40% coinsurance after deductible
Home health care and hospice services	20% coinsurance after deductible	40% coinsurance after deductible
Oxygen and equipment for its administration	20% coinsurance after deductible	40% coinsurance after deductible
Durable medical equipment and repairs–such as wheelchairs, crutches, and hospital beds	20% coinsurance after deductible**	40% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible	40% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, 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	$25 per visit***, no deductible $40 per visit***, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit • At other hospitals or by other covered providers • At or by higher cost share hospitals	 20% coinsurance after deductible 30% coinsurance after deductible	 40% coinsurance after deductible 40% coinsurance after deductible

* 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.

** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).

*** 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 In-Network	Your Cost Out-of-Network
Inpatient Care (including maternity care) in: • Other general hospitals (as many days as medically necessary) • Higher cost share hospitals (as many days as medically necessary)	 20% coinsurance after deductible 30% coinsurance after deductible	 40% coinsurance after deductible 40% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	20% coinsurance after deductible	40% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	20% coinsurance after deductible	40% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drug Benefits* At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible $15 for Tier 1 $30 for Tier 2 $60 for Tier 3	Not covered
Through the designated mail order pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible	Not covered
• Certain covered drugs for: asthma, diabetes, coronary artery disease or risk for cardiovascular disease (concurrently taking high blood pressure medications and high cholesterol medications), and depression associated with any of these conditions***	$15 for Tier 1† $30 for Tier 2 $120 for Tier 3	
• All other covered drugs and supplies	$30 for Tier 1† $60 for Tier 2 $120 for Tier 3	

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs. Your pharmacy coverage includes the Select Home Delivery Program. For a complete description of the program refer to your subscriber certificate and riders. To find out which maintenance drugs are on the Select Home Delivery Pharmacy drug list, call the Member Service number on your ID card, or visit our website at bluecrossma.com/90daymeds.

** Cost share may be waived for certain covered drugs and supplies.

*** For a list of these drugs, contact Blue Cross Blue Shield of Massachusetts or visit the Value-Based Benefits page in the Pharmacy Coverage section at bluecrossma.com.

† Certain generic medications are available through the mail order pharmacy at $9. For more information, go to bluecrossma.com/mail-order-pharmacy.

Get the Most from Your Plan

Visit us at **bluecrossma.com** or call **1-800-588-5507** to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program **Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs** This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs. (See your subscriber certificate for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your subscriber certificate for details.)	$150 per calendar year per policy
24/7 Nurse Care Line—A 24-hour nurse line to answer your health care questions—call **1-888-247-BLUE (2583)**	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-800-588-5507**, or visit us online at **bluecrossma.com**. Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at **bluecrossma.com/myblue**.

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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BlueCross® BlueShield®

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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MASSACHUSETTS

Translation Resources
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។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

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