



# BLUE CARE ELECT \$500 DEDUCTIBLE

MIIA Greater Lawrence  
Technical High

Plan-Year Deductible: \$500/\$1,000

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 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 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 **\$500** per member (or **\$1,000** per family) for in-network and out-of-network services combined.

## 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.

*Note: If a preferred provider refers you to another provider for covered services (such as a lab or 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.*

## How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider on Find a Doctor at [bluecrossma.com/findadoctor](http://bluecrossma.com/findadoctor). 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.org](http://bluecrossma.org)

## 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 benefit description. 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 plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$5,450** per member (or **\$10,900** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** 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 in-network or out-of-network emergency room services. The 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](http://bluecrossma.org), consult Find a Doctor, or call the Member Service number on your ID card.

## Your Virtual Care Team

Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

## 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 benefit description 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.

## Value Care Offering Coverage

Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

## Dependent Benefits

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



Covered Services	Your Cost In-Network	Your Cost Out-of-Network
<b>Preventive Care</b>		
Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> <li>Ten visits during the first year of life</li> <li>Three visits during the second year of life (age 1 to age 2)</li> <li>Two visits for age 2</li> <li>One visit per calendar year for age 3 and older</li> </ul>	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 routine 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
<b>Outpatient Care</b>		
Emergency room visits	\$75 per visit after deductible (copayment waived if admitted or for an observation stay)	\$75 per visit after deductible (copayment waived if admitted or for an observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> <li>A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care</li> <li>Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</li> </ul>	\$10 per visit, no deductible	20% coinsurance after deductible
Mental health or substance use treatment	\$10 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services <ul style="list-style-type: none"> <li>With a covered provider</li> <li>With the in-network designated telehealth vendor</li> </ul>	Same as in-person visit \$10 per visit, no deductible	Same as in-person visit Only applicable in-network
Chiropractors' office visits	\$10 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$10 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$10 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing, no deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests <ul style="list-style-type: none"> <li>Hospitals</li> <li>Other covered providers</li> </ul>	\$100 per category per service date Nothing, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, 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: <ul style="list-style-type: none"> <li>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</li> <li>Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</li> </ul>	\$10 per visit***, no deductible	20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission after deductible	20% coinsurance after deductible
<b>Inpatient Care (including maternity care)</b>		
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	\$500 per admission after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	\$500 per admission after deductible	20% 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, including supplies (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
<b>Prescription Drug Benefits*</b>		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3	Not covered
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$20 for Tier 1 \$50 for Tier 2 \$75 for Tier 3	Not covered

\* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.

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

Get the Most from Your Plan: Visit us at [bluecrossma.org](https://bluecrossma.org) or call 1-800-782-3675 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 benefit description for details.)

\$300 per calendar year per policy

**Weight Loss Reimbursement:** a program that rewards participation in a qualified weight loss program (See your benefit description for details.)

\$300 per calendar year per policy

#### Mind and Body Wellness Program

Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)

\$300 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 1-800-782-3675, or visit us online at [bluecrossma.org](https://bluecrossma.org).

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: acupuncture visits; 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 benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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