MASSACHUSETTS

Product Coverage Options

HMO

100+ | **Accounts with 100 or more Eligible Employees**

Effective on anniversary dates on or after January 2018

Blue Cross Blue Shield of Massachusetts covers more people in Massachusetts than any other health plan. And we've been rated time and again as a top five health plan nationwide.

Important Information About This Chart

This chart allows you to compare some of the benefits under each of the plans listed. There may be other cost-share features not included in this chart. Please refer to the plan subscriber certificates for full benefit information.

Hospital Choice Cost Sharing (Blue shaded products): These plan designs come with an option to add the Hospital Choice Cost Sharing feature, which results in a lower premium rate. With Hospital Choice Cost Sharing, members are empowered to control their out-of-pocket costs based on the hospital they choose for care. When they choose hospitals that have met our quality benchmarks and are lower cost, they will pay less. This approach provides incentives for members to make more cost-effective provider choices. For a list of higher cost hospitals, see footnote #4 on page 13. For more information, visit bluecrossma.com/hospitalchoice or contact your account executive or broker.

Blue Options (Green shaded products): These health plans include two tiered provider networks called HMO Blue Options v.5 and HMO Blue New England Options v.5. Our Blue Options plans combine financial incentives with tiered-networks, adding even greater value to employers and employees. Members pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at bluecrossma.com and search for HMO Blue Options v.5 or HMO Blue New England Options v.5.

Blue Select (Gray shaded products): These health plans are a limited provider network plan, and include a limited provider network called HMO Blue Select. These plans provide access to a network that is smaller than the Blue Cross Blue Shield of Massachusetts HMO Blue provider network. Under these plans, members have access to network benefits from only the providers in the HMO Blue Select network. For help in finding which providers are included in the HMO Blue Select network, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.com/findadoctor and select HMO Blue Select.

Medicare Creditable Coverage: All plans in this chart, except for Access Blue New England Basic Saver II, 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 chart meet the minimum level of benefits that adult tax filers need to be considered insured and avoid tax penalties in Massachusetts.

Low-Cost Generic Drug Benefit: With all plans, members can get a 90-day supply of select generic medications for only $9 when filled through Express Scripts®´, our mail service pharmacy. Normal prescription guidelines apply.

	Access Blue New England		
	Access Blue New England Enhanced Value	Access Blue New England Saver (HSA Compliant)	Access Blue New England Basic $2,000
Office Visit	Preventive: $0 PCP: $20 Specialist: $30	Preventive: $0 PCP: $15 after Deductible Specialist: $25 after Deductible	Preventive: $0 PCP: $25 after Deductible Specialist: $35 after Deductible
Emergency Room	$150	$150 after Deductible	$200
Inpatient Admissions[1]	$500	Deductible	20% after Deductible
Surgical Day Care[1]	$250	Deductible	20% after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	$50	Deductible	20% after Deductible
Medical Deductible[2] (per plan year, unless noted)	None	$1,500/$3,000—Includes Rx[5]	$2,000/$4,000
Out-of-Pocket Maximum[3] (per plan year unless noted)	Medical: $5,450/$10,900 Rx: $1,000/$2,000	$6,450/$12,900—Includes Rx	Medical: $5,450/$10,900 Rx: $1,000/$2,000
Prescription Drugs	Retail: $15/$30/$50 Mail: $30/$60/$100	AFTER DEDUCTIBLE Retail: $10/$25/$45 Mail: $20/$50/$135	Tier 1: Retail: $15 Mail: $30 Tier 2 and Tier 3: Retail and Mail: $250/$500 Deductible then 50% Coinsurance
Hospital Choice Cost Sharing[4]	Inpatient: $1,500 SDC: $1,250 MRI/CT/PET/NC: $500 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $65	Not Applicable	AFTER DEDUCTIBLE Inpatient: 30% Coinsurance SDC: 30% Coinsurance MRI/CT/PET/NC: 30% Coinsurance Labs: 30% Coinsurance X-ray & other Imaging tests: 30% Coinsurance PT/OT/ST: $75

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

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	Access Blue New England		Blue Choice
	Access Blue New England Basic Saver (HSA Compliant)	Access Blue New England Basic Saver II (HSA Compliant)	Blue Choice®
Office Visit	Preventive: $0 PCP: $60 after Deductible Specialist: $75 after Deductible	Preventive: $0 PCP: $50 after Deductible Specialist: $75 after Deductible	PCP/PLAN APPROVED: Preventive: $0 PCP: $10 Specialist: $10 SELF-REFERRED: 20% after Deductible
Emergency Room	$250 after Deductible	$750 after Deductible	$100
Inpatient Admissions[1]	35% after Deductible	$1,000 after Deductible	PCP/Plan-Approved: $0 Self-Referred: 20% after Deductible
Surgical Day Care[1]	35% after Deductible	$1,000 after Deductible	PCP/Plan-Approved: $0 Self-Referred: 20% after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	35% after Deductible	$1,000 after Deductible	PCP/Plan-Approved: $25 Self-Referred: 20% after Deductible
Medical Deductible[2] (per plan year, unless noted)	$3,000/$5,950—Includes Rx[5]	$3,300/$6,450—Includes Rx[5]	PER CALENDAR YEAR PCP/Plan-Approved: None Self-Referred: $250/$500
Out-of-Pocket Maximum[3] (per plan year unless noted)	$6,450/$12,900—Includes Rx	$6,450/$12,900—Includes Rx	PER CALENDAR YEAR PCP/PLAN APPROVED: Medical: $5,450/$10,900 Rx: $1,000/$2,000 SELF-REFERRED: Medical: $6,450/$12,900
Prescription Drugs	AFTER DEDUCTIBLE Retail: $15/$30/$50 Mai: $30/$60/$150	AFTER DEDUCTIBLE Retail: $15/50%/50% Mail: $30/50%/50%	PCP/Plan-Approved: Retail: $10/$25/$45 Mail: $20/$50/$90 Self-Referred: Not covered
Hospital Choice Cost Sharing[4]	Not Applicable	Not Applicable	Not Applicable

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

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	Blue Choice	Blue Choice New England	
	Blue Choice® Value Plus	Blue Choice® New England	Blue Choice® New England Value Plus
Office Visit	PCP/PLAN APPROVED: Preventive: $0 PCP: $15 Specialist: $15 SELF-REFERRED: 20% after Deductible	PCP/PLAN APPROVED: Preventive: $0 PCP: $10 Specialist: $10 SELF-REFERRED: 20% after Deductible	PCP/PLAN APPROVED: Preventive: $0 PCP: $15 Specialist: $15 SELF-REFERRED: 20% after Deductible
Emergency Room	$100	$100	$100
Inpatient Admissions[1]	PCP/Plan-Approved: $250 Self-Referred: 20% after Deductible	PCP/Plan-Approved: $0 Self-Referred: 20% after Deductible	PCP/Plan-Approved: $250 Self-Referred: 20% after Deductible
Surgical Day Care[1]	PCP/Plan-Approved: $150 Self-Referred: 20% after Deductible	PCP/Plan-Approved: $0 Self-Referred: 20% after Deductible	PCP/Plan-Approved: $150 Self-Referred: 20% after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	PCP/Plan-Approved: $25 Self-Referred: 20% after Deductible	PCP/Plan-Approved: $25 Self-Referred: 20% after Deductible	PCP/Plan-Approved: $25 Self-Referred: 20% after Deductible
Medical Deductible[2] (per plan year, unless noted)	PER CALENDAR YEAR PCP/Plan-Approved: None Self-Referred: $500/$1,000	PER CALENDAR YEAR PCP/Plan-Approved: None Self-Referred: $250/$500	PER CALENDAR YEAR PCP/Plan-Approved: None Self-Referred: $500/$1,000
Out-of-Pocket Maximum[3] (per plan year unless noted)	PER CALENDAR YEAR PCP/PLAN APPROVED: Medical: $5,450/$10,900 Rx: $1,000/$2,000 SELF-REFERRED: Medical: $6,450/$12,900	PER CALENDAR YEAR PCP/PLAN APPROVED: Medical: $5,450/$10,900 Rx: $1,000/$2,000 SELF-REFERRED: Medical: $6,450/$12,900	PER CALENDAR YEAR PCP/PLAN APPROVED: Medical: $5,450/$10,900 Rx: $1,000/$2,000 SELF-REFERRED: Medical: $6,450/$12,900
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: $10/$25/$45 Mail: $20/$50/$90 Self-Referred: Not covered
Hospital Choice Cost Sharing[4]	Not Applicable	Not Applicable	Not Applicable

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

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	Blue Choice New England	Blue Select	HMO Blue
	Blue Choice® New England Deductible	HMO Blue Select Deductible	HMO Blue
Office Visit	PCP/PLAN APPROVED: Preventive: $0 PCP: $20 Specialist: $35 SELF-REFERRED: 20% after Deductible	PCP: $20 Specialist: $35	Preventive: $0 PCP: $10 Specialist: $25
Emergency Room	$150	$150	$100
Inpatient Admissions[1]	PCP/Plan-Approved: Deductible Self-Referred: 20% after Deductible	Deductible	$0
Surgical Day Care[1]	PCP/Plan-Approved: Deductible Self-Referred: 20% after Deductible	Deductible	$0
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	PCP/Plan-Approved: Deductible Self-Referred: 20% after Deductible	Deductible	$25
Medical Deductible[2] (per plan year, unless noted)	PER CALENDAR YEAR PCP/Plan-Approved: $1,000/$2,000 Self-Referred: $2,000/$4,000	$1,000/$2,000	None
Out-of-Pocket Maximum[3] (per plan year unless noted)	PER CALENDAR YEAR PCP/PLAN APPROVED: Medical: $5,450/$10,900 Rx: $1,000/$2,000 SELF-REFERRED: Medical: $6,450/$12,900	Medical: $5,450/$10,900 Rx: $1,000/$2,000—Rx	Medical: $5,450/$10,900 Rx: $1,000/$2,000
Prescription Drugs	PCP/Plan-Approved: Retail: $15/$30/$50 Mail: $30/$60/$150 Self-Referred: Not covered	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $10/$25/$45 Mail: $20/$50/$90
Hospital Choice Cost Sharing[4]	Not Applicable	Not Applicable	Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $475 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $60

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

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	HMO Blue		
	HMO Blue Value Plus	HMO Blue Enhanced Value	HMO Blue Options v.5
Office Visit	Preventive: $0 PCP: $15 Specialist: $30	Preventive: $0 PCP: $20 Specialist: $35	Preventive: $0 PCP: EBT: $15[6] SBT: $25[6] BBT: $45[6] Specialist: $45
Emergency Room	$100	$150	$150
Inpatient Admissions[1]	$250	$500	EBT: $250[6] SBT: $500[6] ($300 for select hospitals[7]) BBT: $1,000[6]
Surgical Day Care[1]	$150	$250	EBT: $150[6] SBT: $250[6] BBT: $500[6]
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	$25	$50	EBT: $75[6] SBT: $150[6] BBT: $250[6] Other Network Providers: $75
Medical Deductible[2] (per plan year, unless noted)	None	None	None
Out-of-Pocket Maximum[3] (per plan year unless noted)	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
Prescription Drugs	Retai: $10/$25/$45 Mail: $20/$50/$90	Retail: $15/$30/$50 Mail: $30/$60/$100	Retail: $15/$30/$50 Mail: $30/$60/$150
Hospital Choice Cost Sharing[4]	Inpatient: $1,250 SDC: $1,150 MRI/CT/PET/NC: $475 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $65	Inpatient: $1,500 SDC: $1,250 MRI/CT/PET/NC: $500 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $70	Not Applicable

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

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	HMO Blue		
	HMO Blue Premier Value	HMO Blue $1,000 Deductible	HMO Blue $2,000 Deductible
Office Visit	Preventive: $0 PCP: $25 Specialis: $40	Preventive: $0 PCP: $20 Specialist: $35	Preventive: $0 PCP: $20 Specialist: $35
Emergency Room	$150	$100 after Deductible	$100 after Deductible
Inpatient Admissions[1]	Deductible	Deductible	Deductible
Surgical Day Care[1]	$250	Deductible	Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	$75	Deductible	Deductible
Medical Deductible[2] (per plan year, unless noted)	Inpatient—$1,000/$2,500	$1,000/$2,000	$2,000/$4,000
Out-of-Pocket Maximum[3] (per plan year unless noted)	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
Prescription Drugs	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150
Hospital Choice Cost Sharing[4]	Inpatient: $1,000 after Deductible SDC: $1,250 MRI/CT/PET/NC: $525 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $75	AFTER DEDUCTIBLE Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $70	AFTER DEDUCTIBLE Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $70

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	HMO Blue	HMO Blue New England	
	HMO Blue Options Deductible v.5	HMO Blue New England	HMO Blue New England Value Plus
Office Visit	Preventive: $0 PCP: EBT: $15[6] SBT: $25[6] BBT: $50[6] Specialist: $50	Preventive: $0 PCP: $10 Specialist: $25	Preventive: $0 PCP: $15 Specialist: $30
Emergency Room	$150	$100	$100
Inpatient Admissions[1]	EBT: $150[6] SBT: $150 after Deductible[6] ($200 for select hospitals[7]) BBT: $1,000 after Deductible[6]	$0	$250
Surgical Day Care[1]	EBT: $150[6] SBT: $150 after Deductible[6] ($200 for select hospitals[7]) BBT: $1,000 after Deductible[6] Other Network Providers: $50	$0	$150
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	EBT: $50[6] SBT: $50 after Deductible[6] BBT: $450 after Deductible[6] Other Network Providers: $50	$25	$25
Medical Deductible[2] (per plan year, unless noted)	EBT: None SBT: $500/$1,000 BBT: $2,000/$4,000	None	None
Out-of-Pocket Maximum[3] (per plan year unless noted)	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
Prescription Drugs	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $10/$25/$45 Mail: $20/$50/$90	Retail: $10/$25/$45 Mail: $20/$50/$90
Hospital Choice Cost Sharing[4]	Not Applicable	Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $475 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $60	Inpatient: $1,250 SDC: $1,150 MRI/CT/PET/NC: $475 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $65

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

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	HMO Blue New England		
	HMO Blue New England Enhanced Value	HMO Blue New England Value	HMO Blue New England Options v.5
Office Visit	Preventive: $0 PCP: $20 Specialist: $35	Preventive: $0 PCP: $25 Specialist: $40	Preventive: $0 PCP: EBT: $15[6] SBT: $25[6] BBT: $45[6] Specialist: $45
Emergency Room	$150	$150	$150
Inpatient Admissions[1]	$500	$500	EBT: $250[6] SBT: $500[6] ($300 for select hospitals[7]) BBT: $1,000[6]
Surgical Day Care[1]	$250	$250	EBT: $150[6] SBT: $250[6] BBT: $500[6]
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	$50	$75	EBT: $75[6] SBT: $150[6] BBT: $250[6] Other Network Providers: $75
Medical Deductible[2] (per plan year, unless noted)	None	None	None
Out-of-Pocket Maximum[3] (per plan year unless noted)	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
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[4]	Inpatient: $1,500 SDC: $1,250 MRI/CT/PET/NC: $500 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $70	Inpatient: $1,500 SDC: $1,250 MRI/CT/PET/NC: $525 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $75	Not Applicable

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	HMO Blue New England		
	HMO Blue New England Premier Value	HMO Blue New England Premier Value with Coinsurance	HMO Blue New England $500 Deductible
Office Visit	Preventive: $0 PCP: $25 Specialist: $40	Preventive: $0 PCP: $25 Specialist: $40	Preventive: $0 PCP: $20 Specialist: $35
Emergency Room	$150	$200	$150
Inpatient Admissions[1]	Deductible	Deductible	Deductible
Surgical Day Care[1]	$250	35% Coinsurance	Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	$75	35% Coinsurance	Deductible
Medical Deductible[2] (per plan year, unless noted)	Inpatient—$1,000/$2,500	Inpatient—$1,000/$2,500	$500/$1,000
Out-of-Pocket Maximum[3] (per plan year unless noted)	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
Prescription Drugs	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150
Hospital Choice Cost Sharing[4]	Inpatient: $1,000 after Deductible SDC: $1,250 MRI/CT/PET/NC: $525 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $75	Inpatient: $1,000 after Deductible SDC: 50% Coinsurance MRI/CT/PET/NC: 50% Coinsurance Labs: 50% Coinsurance X-ray & other imaging tests: 50% Coinsurance PT/OT/ST: $75	AFTER DEDUCTIBLE Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $70

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	HMO Blue New England		
	HMO Blue New England $1,000 Deductible	HMO Blue New England $1,500 Deductible	HMO Blue New England $2,000 Deductible
Office Visit	Preventive: $0 PCP: $20 Specialist: $35	Preventive: $0 PCP: $20 Specialist; $35	Preventive: $0 PCP: $20 Specialist: $35
Emergency Room	$150	$150	$150
Inpatient Admissions[1]	Deductible	Deductible	Deductible
Surgical Day Care[1]	Deductible	Deductible	Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	Deductible	Deductible	Deductible
Medical Deductible[2] (per plan year, unless noted)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000
Out-of-Pocket Maximum[3] (per plan year unless noted)	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
Prescription Drugs	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150	Retail: $15/$30/$50 Mail: $30/$60/$150
Hospital Choice Cost Sharing[4]	AFTER DEDUCTIBLE Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $70	AFTER DEDUCTIBLE Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 OP Diag labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $70	AFTER DEDUCTIBLE Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $70

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

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	HMO Blue New England		
	HMO Blue New England $3,000 Deductible	HMO Blue New England Options Deductible v.5	HMO Blue New England Options Deductible II v.5
Office Visit	Preventive: $0 PCP: $25 Specialist: $40	Preventive: $0 PCP: EBT: $15[6] SBT: $25[6] BBT: $50[6] Specialist: $50	Preventive: $0 PCP: EBT: $20[6] SBT: $30[6] BBT: $50[6] Specialist: $50
Emergency Room	$150	$150	$200
Inpatient Admissions[1]	Deductible	EBT: $150[6] SBT: $150 after Deductible[6] ($200 for select hospitals[7]) BBT: $1,000 after Deductible[6]	EBT: $250[6] SBT: $250 after Deductible[6] ($300 for select hospitals[7]) BBT: $1,500 after Deductible[6]
Surgical Day Care[1]	Deductible	EBT: $150[6] SBT; $150 after Deductible[6] ($200 for select hospitals[7]) BBT: $1,000 after Deductible[6]	EBT: $250[6] SBT: $250 after Deductible[6] ($300 for select hospitals[7]) BBT: $1,500 after Deductible[6]
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	Deductible	EBT: $50[6] SBT: $50 after Deductible[6] BBT: $450 after Deductible[6] Other Network Providers: $50	EBT: $75[6] SBT: $75 after Deductible[6] BBT: $450 after Deductible[6] Other Network Providers: $75
Medical Deductible[2] (per plan year, unless noted)	$3,000/$6,000	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[3] (per plan year unless noted)	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
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[4]	AFTER DEDUCTIBLE Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 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		
	HMO Blue New England $1000 Deductible with Coinsurance	HMO Blue New England Options Deductible III v.5	HMO Blue New England Basic Copayment
Office Visit	Preventive: $0 PCP: $20 Specialist: $35	Preventive: $0 PCP: EBT: $20[6] SBT: $35[6] BBT: $55[6] Specialist: $55	Preventive: $0 PCP: $60 Specialist: $75
Emergency Room	20% Coinsurance after Deductible	$250	$750 after Deductible
Inpatient Admissions[1]	20% after Deductible	EBT: Deductible[6] SBT: $500 after Deductible[6] ($50 for select hospitals[7]) BBT: $1,500 after Deductible[6]	$1,000 after Deductible
Surgical Day Care[1]	20% after Deductible	EBT: Deductible[6] SBT: $500 after Deductible[6] ($50 for select hospitals[7]) BBT: $1,500 after Deductible[6]	$1,000 after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	20% after Deductible	EBT: Deductible[6] SBT: $75 after Deductible[6] BBT: $450 after Deductible[6] Other network providers: $0	$1,000 after Deductible
Medical Deductible[2] (per plan year)	$1,000/$2,000	$2,000/$4,000	$2,000/$4,000
Out-of-Pocket Maximum[3] (per plan year unless noted)	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
Prescription Drugs	Retail: $10/$25/$45 Mail: $20/$50/$135	Retail: $20/$40/$60 Mail: $40/$80/$180	Retail: $20/$40/$60 Mail: $40/$80/$180
Hospital Choice Cost Sharing[4]	AFTER DEDUCTIBLE Inpatient: 30% Coinsurance SDC: 30% Coinsurance MRI/CT/PET/NC: 30% Coinsurance Labs: 30% Coinsurance X-ray & other imaging tests: 30% Coinsurance PT/OT/ST: $75	Not Applicable	Not Applicable

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

KEY: **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	HMO Blue New England
	HMO Blue New England Basic Coinsurance
Office Visit	Preventive: $0 PCP: $60 Specialist: $75
Emergency Room	35% Coinsurance after Deductible
Inpatient Admissions[1]	35% after Deductible
Surgical Day Care[1]	35% after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	35% after Deductible
Medical Deductible[2] (per plan year, unless noted)	$2,000/$4,000
Out-of-Pocket Maximum[3] (per plan year unless noted)	Medical: $5,450/$10,900 Rx: $1,000/$2,000
Prescription Drugs	Tier 1: Retail: $15 Mail: $30 Tier 2 and Tier 3: Retail and Mail: 50% Coinsurance
Hospital Choice Cost Sharing[4]	Not Applicable

Footnotes

1. This is the cost sharing for services rendered at hospitals other than those that are designated as higher cost.
2. The two deductible amounts refer to individual and family.
3. The two out-of-pocket maximum amounts refer to individual and family.
4. Higher-cost hospitals are: Baystate Medical Center, Brigham and Women's Hospital, Cape Cod Hospital, Boston Children's Hospital (other than Boston Children's Hospital locations at Lexington, Peabody, and Waltham), Dana-Farber Cancer Institute, Fairview Hospital, Massachusetts General Hospital, UMass Memorial Medical Center—Memorial Campus, and UMass Memorial Medical Center—University Campus.
5. Entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.
6. 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 services 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.
7. To provide geographic access to members, the lower Standard Benefits Tier copayment applies for Athol Memorial Hospital, Baystate Franklin Medical Center, Berkshire Medical Center, Falmouth Hospital, Martha's Vineyard Hospital, and Nantucket Cottage Hospital. For HMO Blue Options v.5 only, the lower Standard Benefits Tier copayment applies to Southwestern Vermont Medical Center in addition to the hospitals listed.

LEGEND: ☐ **Hospital Choice Cost Sharing** ☐ **Blue Options** ☐ **Blue Select**

KEY: EBT: Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

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