MASSACHUSETTS

Product Coverage Options

PPO

100+ | Accounts with 100 or more Eligible Employees

Effective on anniversary dates on or after January 2019

At Blue Cross Blue Shield of Massachusetts, we're leading the way to better health and lower costs. Rated among the nation's best health plans for member satisfaction and quality, we cover more people in Massachusetts than any other health plan.

TWO YEARS IN A ROW

We ranked "Highest in Member Satisfaction among Commercial Health Plans in Massachusetts" by J.D. Power in 2017 and 2018.

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'll 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 11. For more information, visit bluecrossma.com/hospitalchoice or contact your account executive or broker.

Blue Options (Green shaded products): These health plans include a tiered provider network called Preferred Blue® PPO 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 Preferred Blue PPO Options v.5.

Medicare Creditable Coverage: All plans in this chart, except for Preferred Blue® PPO Basic Saver, 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, except for Blue Care® Elect $4,500 Deductible, 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.

	Blue Care® Elect		
	Blue Care® Elect Preferred	Blue Care® Elect Value Plus	Blue Care® Elect Enhanced Value
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $20 **OON:** 20% Coinsurance after Deductible
Emergency Room	$100	$100	$150
Inpatient Admissions[1]	**IN:** $0 **OON:** 20% Coinsurance after Deductible	**IN:** $250 **OON:** 20% Coinsurance after Deductible	**IN:** $500 **OON:** 20% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** $0 **OON:** 20% Coinsurance after Deductible	**IN:** $150 **OON:** 20% Coinsurance after Deductible	**IN:** $250 **OON:** 20% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** $25 **OON:** 20% Coinsurance after Deductible	**IN:** $25 **OON:** 20% Coinsurance after Deductible	**IN:** $50 **OON:** 20% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN:** None **OON:** $250/$500	**IN:** None **OON:** $500/$1,000	**IN:** None **OON:** $500/$1,000
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000
Prescription Drugs	**IN:** Retail: $10/$25/$45 Mail: $20/$50/$90 **OON:** Not covered	**IN:** Retail: $10/$25/$45 Mail: $20/$50/$90 **OON:** Not covered	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$100 **OON:** Not covered
Hospital Choice Cost Sharing[4]	Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $475 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $50	Inpatient: $1,250 SDC: $1,150 MRI/CT/PET/NC: $475 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $50	Inpatient: $1,500 SDC: $1,250 MRI/CT/PET/NC: $500 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $55

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Blue Care® Elect		
	Blue Care® Elect Preferred 90	Blue Care® Elect Preferred 90 with Copayment	Blue Care® Elect $1,000 Deductible
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 after Deductible **OON:** 20% Coinsurance after Deductible
Emergency Room	10% Coinsurance after Deductible	$150	$150 after Deductible
Inpatient Admissions[1]	**IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible	**IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible	**IN:** $250 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible	**IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN and OON combined:** $250/$500	**IN and OON combined:** $250/$500	**IN and OON combined:** $1,000/$2,500
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000
Prescription Drugs	**IN:** Retail: $10/$25/$45 Mail: $20/$50/$90 **OON:** Not covered	**IN:** Retail: $10/$25/$45 Mail: $20/$50/$90 **OON:** Not covered	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Not covered
Hospital Choice Cost Sharing[4]	**IN:** After Deductible Inpatient: 20% Coinsurance SDC: 20% Coinsurance MRI/CT/PET/NC: 20% Coinsurance Labs: 20% Coinsurance X-ray & other imaging tests: 20% Coinsurance PT/OT/ST: 20% Coinsurance	**IN:** After Deductible Inpatient: 20% Coinsurance SDC: $1,250 MRI/CT/PET/NC: 20% Coinsurance Labs: 20% Coinsurance X-ray & other imaging tests: 20% Coinsurance PT/OT/ST: $50 (no Deductible)	**IN:** After Deductible Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $50

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Blue Care® Elect		
	Blue Care® Elect $1,500 Deductible	Blue Care® Elect Preferred 80 with Copayment	Blue Care® Elect Saver $1,500 (HSA Compliant)
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 after Deductible **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $20 **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance MEDICAL **IN:** Deductible **OON:** 20% Coinsurance after Deductible
Emergency Room	$150 after Deductible	$150	$150 after Deductible
Inpatient Admissions[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** $250 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN and OON combined:** $1,500/$3,750	**IN and OON combined:** $500/$1,000	**IN and OON combined:** $1,500/$3,000—includes Rx[5]
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** $6,450/$12,900—Includes Rx
Prescription Drugs	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Not covered	**IN:** Retail: $10/$25/$45 Mail: $20/$50/$90 **OON:** Not covered	After Deductible **IN:** Retail: $10/$25/$45 Mail: $20/$50/$135 **OON:** Retail: $20/$50/$90 Mail: Not covered
Hospital Choice Cost Sharing[4]	**IN:** After Deductible Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $50	**IN:** After Deductible Inpatient: 30% Coinsurance SDC: $1,250 MRI/CT/PET/NC: 30% Coinsurance Labs: 30% Coinsurance X-ray & other imaging tests: 30% Coinsurance PT/OT/ST: $55 (no Deductible)	Not Applicable

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Blue Care® Elect		
	Blue Care® Elect Preferred 80	Blue Care® Elect $2,000 Deductible	Blue Care® Elect $3,000 Deductible
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 after Deductible **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 after Deductible **OON:** 20% Coinsurance after Deductible
Emergency Room	20% Coinsurance after Deductible	$150 after Deductible	$150 after Deductible
Inpatient Admissions[1]	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN and OON combined:** $500/$1,000	**IN and OON combined:** $2,000/$4,000	**IN and OON combined:** $3,000/$7,500
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000
Prescription Drugs	**IN:** Retail: $10/$25/$45 Mail: $20/$50/$90 **OON:** Not covered	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Not covered	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Not covered
Hospital Choice Cost Sharing[4]	**IN:** 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: 30% Coinsurance	**IN:** After Deductible Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $50	**IN:** After Deductible Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $50

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Blue Care® Elect		
	Blue Care® Elect Saver $2,700 (HSA Compliant)	Blue Care® Elect $4,500	Blue Care® Elect Saver 90 (HSA Compliant)
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance MEDICAL **IN:** Deductible **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** $45 after Deductible MEDICAL **IN:** $25 after Deductible **OON:** $45 after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance MEDICAL **IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible
Emergency Room	$150 after Deductible	$150 after Deductible	$150 after Deductible
Inpatient Admissions[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 10% Coinsurance after Deductible **OON:** 30% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN and OON combined:** $2,700/$5,400—includes Rx[5]	**IN and OON combined:** $4,500/$9,000	**In and OON combined:** $1,500/$3,000—Includes Rx[5]
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN and OON combined:** $6,450/$12,900—Includes Rx	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** $6,450/$12,900—Includes Rx
Prescription Drugs	After Deductible **IN:** Retail: $10/$25/$45 Mail: $20/$50/$135 **OON:** Retail: $20/$50/$90 Mail: Not covered	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Not covered	After Deductible **IN:** Retail: $10/$25/$45 Mail: $20/$50/$135 **OON:** Retail: $20/$50/$90 Mail: Not covered
Hospital Choice Cost Sharing[4]	Not Applicable	Not Applicable	Not Applicable

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue®		
	Preferred Blue® PPO Options v.5	Preferred Blue® PPO $1,000 Deductible	Preferred Blue® PPO Saver $1,500 (HSA Compliant)
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** EBT: $15[6] SBT: $25[6] BBT: $45[6] Other Network Providers: $45 **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 after Deductible **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance MEDICAL **IN:** Deductible **OON:** 20% Coinsurance after Deductible
Emergency Room	$150	$150 after Deductible	$150 after Deductible
Inpatient Admissions[1]	**IN:** EBT: $250[6] SBT: $500[6] ($300 for select hospitals[7]) BBT: $1,000[6] **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** EBT: $150[6] SBT: $250[6] BBT: $500[6] **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** EBT: $75[6] SBT: $150[6] BBT: $250[6] Other Network Providers: $75 **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN:** None **OON:** $2,000/$4,000	**IN and OON combined:** $1,000/$2,500	**IN and OON combined:** $1,500/$3,000—Includes Rx[5]
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** $6,450/$12,900—Includes Rx
Prescription Drugs	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Retail: $30/$60/$100 Mail: Not covered	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Retail: $30/$60/$100 Mail: Not covered	After Deductible **IN:** Retail: $10/$25/$45 Mail: $20/$50/$135 **OON:** Retail: $20/$50/$90 Mail: Not covered
Hospital Choice Cost Sharing[4]	Not Applicable	**IN:** After Deductible Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $50	Not Applicable

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue®		
	Preferred Blue® PPO 80 with Copayment	Preferred Blue® PPO $2,000 Deductible	Preferred Blue® PPO Saver $2,000 (HSA Compliant)
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $20 **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $15 after Deductible **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance MEDICAL **IN:** Deductible **OON:** 20% Coinsurance after Deductible
Emergency Room	$150	$150 after Deductible	$150 after Deductible
Inpatient Admissions[1]	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** $250 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** Deductible **OON:** 20% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN and OON combined:** $500/$1,000	**IN and OON combined:** $2,000/$4,000	**IN and OON combined:** $2,000/$4,000—Includes Rx[5]
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN and OON combined:** $6,450/$12,900—Includes Rx
Prescription Drugs	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Retail: $30/$60/$100 Mail: Not covered	**IN:** Retail: $15/$30/$50 Mail: $30/$60/$150 **OON:** Retail: $30/$60/$100 Mail: Not covered	After Deductible **IN:** Retail: $10/$25/$45 Mail: $20/$50/$135 **OON:** Retail: $20/$50/$90 Mail: Not covered
Hospital Choice Cost Sharing[4]	**IN:** After Deductible Inpatient: 30% Coinsurance SDC: $1,250 MRI/CT/PET/NC: 30% Coinsurance Labs: 30% Coinsurance X-ray & other imaging tests: 30% Coinsurance PT/OT/ST: $55 (no Deductible)	**IN:** After Deductible Inpatient: $1,000 SDC: $1,000 MRI/CT/PET/NC: $450 Labs: $35 X-ray & other imaging tests: $100 PT/OT/ST: $50	Not Applicable

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue®		
	Preferred Blue® PPO Saver $2,900 (HSA Compliant)	Preferred Blue® PPO Basic Copayment	Preferred Blue® PPO Basic Coinsurance
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance MEDICAL **IN:** Deductible **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $65 **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $60 **OON:** 20% Coinsurance after Deductible
Emergency Room	$150 after Deductible	$750 after In-Network Deductible	35% Coinsurance after In-Network Deductible
Inpatient Admissions[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** $1,000 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 35% Coinsurance after Deductible **OON:** 55% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** $1,000 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 35% Coinsurance after Deductible **OON:** 55% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** Deductible **OON:** 20% Coinsurance after Deductible	**IN:** $1,000 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 35% Coinsurance after Deductible **OON:** 55% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN and OON combined:** $2,900/$5,800—includes Rx[5]	**IN:** $2,000/$4,000 **OON:** $4,000/$8,000	**IN:** $2,000/$4,000 **OON:** $4,000/$8,000
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN and OON combined:** $6,450/$12,900—Includes Rx	**IN:** Medical: $5,450/$10,900 Rx: $1,000/$2,000 **OON:** Medical: $10,900/$21,800 Rx: $2,000/$4,000	**IN:** Medical: $5,450/$10,900 Rx: $1,000/$2,000 **OON:** Medical: $10,900/$21,800 Rx: $2,000/$4,000
Prescription Drugs	After Deductible **IN:** Retail: $10/$25/$45 Mail: $20/$50/$135 **OON:** Retail: $20/$50/$90 Mail: Not covered	**IN:** Retail: $20/$40/$60 Mail: $40/$80/$180 **OON:** Retail: $40/$80/$120 Mail: Not covered	**IN:** Tier 1: Retail: $15 Mail: $30 Tier 2 and Tier 3: Retail and Mail: 50% Coinsurance **OON:** Tier 1: Retail: $30 Tier 2 and Tier 3: Retail: 50% Coinsurance Mail: Not covered
Hospital Choice Cost Sharing[4]	Not Applicable	Not Applicable	Not Applicable

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue®		
	Preferred Blue® PPO Basic Saver (HSA Compliant)	Preferred Blue® PPO Basic $2,000	Preferred Blue® PPO Options Deductible II v.5
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance MEDICAL **IN:** $60 after Deductible **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** $25 **OON:** 20% Coinsurance after Deductible	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** EBT: $20[6] SBT: $35[6] BBT: $55[6] Other: $55 **OON:** 20% Coinsurance after Deductible
Emergency Room	$750 after In-Network Deductible	$250	$250
Inpatient Admissions[1]	**IN:** $1,000 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** EBT: $500[6] SBT: $500 after Deductible[6] ($550 for select hospitals[7]) BBT: $1,500 after Deductible[6] **OON:** 20% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** $1,000 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** EBT: $500[6] SBT: $500 after Deductible[6] ($550 for select hospitals[7]) BBT: $1,500 after Deductible[6] **OON:** 20% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** $1,000 after Deductible **OON:** 20% Coinsurance after Deductible	**IN:** 20% Coinsurance after Deductible **OON:** 40% Coinsurance after Deductible	**IN:** EBT: $75[6] SBT: $75 after Deductible[6] BBT: $450 after Deductible[6] Other network providers: $75 **OON:** 20% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN:** $3,300/$6,450—Includes Rx[5] **OON:** $6,300/$10,000—Includes Rx[5]	**IN and OON combined:** $2,000/$4,000	**IN:** EBT: None SBT: $500/$1,000 BBT: $2,000/$4,000 **OON:** $4,000/$8,000
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN:** Medical: $6,450/$12,900 —Includes Rx **OON:** Medical: $11,000/$23,000 —Includes Rx	**IN and OON combined:** Medical: $5,450/$10,900 Rx: $1,000/$2,000	**IN:** Medical: $4,850/$9,700 Rx: $2,000/$4,000 **OON:** Medical: $7,500/$15,000 Rx: $2,000/$4,000
Prescription Drugs	After Deductible **IN:** Tier 1: Retail: $15 Mail: $30 Tier 2 and Tier 3: Retail and Mail: 50% Coinsurance **OON:** Tier 1: Retail: $30 Tier 2 and Tier 3: Retail: 50% Coinsurance Mail: Not covered	**IN:** Tier 1: Retail: $15 Mail: $30 Tier 2 and Tier 3: Retail and Mail: $250/$500 Deductible then 50% Coinsurance **OON:** Tier 1: Retail: $30 Tier 2 and Tier 3: Retail: $250/$500 Deductible then 50% Coinsurance Mail: Not covered	**IN:** Retail: $20/$40/$60/$120 Mail: $40/$80/$120/$360 **OON:** Retail: $40/$80/$120/$240 Mail: Not covered
Hospital Choice Cost Sharing[4]	Not Applicable	**IN:** 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: $60 (no Deductible)	Not Applicable

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue®
	Preferred Blue® PPO Options Deductible III v.5
Office Visit	PREVENTIVE **IN:** $0 **OON:** 20% Coinsurance after Deductible MEDICAL **IN:** EBT: $20[6] SBT: $35[6] BBT: $55 [6] Other: $55 **OON:** 20% Coinsurance after Deductible
Emergency Room	$250
Inpatient Admissions[1]	**IN:** EBT: Deductible[6] SBT: $500 after Deductible[6] ($50 for select hospitals[7]) BBT: $1,500 after Deductible[6] **OON:** 20% Coinsurance after Deductible
Surgical Day Care[1]	**IN:** EBT: Deductible[6] SBT: $500 after Deductible[6] ($50 for select hospitals[7]) BBT: $1,500 after Deductible[6] **OON:** 20% Coinsurance after Deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests[1]	**IN:** EBT: Deductible[6] SBT: $75 after Deductible[6] BBT: $450 after Deductible[6] Other network providers: $0 **OON:** 20% Coinsurance after Deductible
Medical Deductible[2] (Per Plan Year)	**IN:** $2,000/$4,000 **OON:** $4,000/$8,000
Out-of-Pocket Maximum[3] (Per Plan Year Unless Noted)	**IN:** Medical: $5,850/$11,700 Rx: $1,000/$2,000 **OON:** Medical: $7,500/$15,000 Rx: $2,000/$4,000
Prescription Drugs	**IN:** Retail: $15/$30/$60/$120 Mail: $30/$60/$120/$360 **OON:** Retail: $30/$60/$120/$240 Mail: Not covered
Hospital Choice Cost Sharing[4]	Not Applicable

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

KEY: IN: In-network **OON:** Out-of-Network **EBT:** Enhanced Benefits Tier **SBT:** Standard Benefits Tier **BBT:** Basic Benefits Tier

FOOTNOTES LOCATED ON THE LAST PAGE

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.

MASSACHUSETTS

187014

55-1893 (9/18)