

PPO

100+

Accounts with 100 or more Eligible Employees

Effective on anniversary dates on or after January 2020

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.



THREE YEARS IN A ROW

We ranked "Highest in Member Satisfaction among Commercial Health Plans in Massachusetts" by J.D. Power in 2017, 2018, and 2019.

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 #6 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 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 for adult tax filers 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
Deductible ¹	IN: None OON: \$250/\$500	IN: None OON: \$500/\$1,000	IN: None OON: \$500/\$1,000
Out-of-Pocket Maximum ²	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
Office Visit	IN: Preventive: \$0 Primary Care: \$15 Specialist: \$15 OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$15 Specialist: \$15 OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$20 Specialist: \$20 OON: 20% coinsurance after deductible
Emergency Room	\$100	\$100	\$150
Inpatient Admissions ⁵	IN: \$0 OON: 20% coinsurance after deductible	IN: \$250 OON: 20% coinsurance after deductible	IN: \$500 OON: 20% coinsurance after deductible
Surgical Day Care	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 ³	IN: \$25 OON: 20% coinsurance after deductible	IN: \$25 OON: 20% coinsurance after deductible	IN: \$50 OON: 20% coinsurance after deductible
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 ⁶	Inpatient: \$1,000 SDC: \$1,000 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$475 PT/OT/ST: \$50	Inpatient: \$1,250 SDC: \$1,150 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$475 PT/OT/ST: \$50	Inpatient: \$1,500 SDC: \$1,250 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$500 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 SDC: Surgical Day Care PT/OT/ST: Physical/Occupational/Speech Therapy

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
Deductible ¹	IN and OON combined: \$250/\$500	IN and OON combined: \$250/\$500	IN and OON combined: \$1,000/\$2,500
Out-of-Pocket Maximum ²	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
Office Visit	IN: Preventive: \$0 Primary Care: 10% coinsurance after deductible Specialist: 10% coinsurance after deductible OON: 30% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$15 Specialist: \$15 OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% coinsurance after deductible
Emergency Room	10% coinsurance after deductible	\$150	\$150 after deductible
Inpatient Admissions ⁵	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 ³	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 ⁴	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
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 ⁶	After deductible Inpatient: 20% coinsurance SDC: 20% coinsurance Labs: 20% coinsurance X-rays and other imaging tests: 20% coinsurance MRI/CT/PET/NC: 20% coinsurance PT/OT/ST: 20% coinsurance	After deductible Inpatient: 20% coinsurance SDC: \$1,250 Labs: 20% coinsurance X-rays and other imaging tests: 20% coinsurance MRI/CT/PET/NC: 20% coinsurance PT/OT/ST: \$50, no deductible	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$450 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 **SDC:** Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

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)
Deductible ¹	IN and OON combined: \$1,500/\$3,750	IN and OON combined: \$500/\$1,000	IN and OON combined: \$1,500/\$3,000 ³
Out-of-Pocket Maximum ²	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
Office Visit	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$20 Specialist: \$20 OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)
Emergency Room	\$150 after deductible	\$150	\$150 after deductible
Inpatient Admissions ⁵	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 ⁴	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 ⁵	IN: Deductible OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
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 ⁶	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$450 PT/OT/ST: \$50	After deductible Inpatient: 30% coinsurance SDC: \$1,250 Labs: 30% coinsurance X-rays and other imaging tests: 30% coinsurance MRI/CT/PET/NC: 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 **SDC:** Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

**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
Deductible ¹	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 ²	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
Office Visit	IN: Preventive: \$0 Primary Care: 20% coinsurance after deductible Specialist: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	\$150 after deductible	\$150 after deductible
Inpatient Admissions ⁵	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 ³	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 ⁵	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
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 ⁶	After deductible Inpatient: 30% coinsurance SDC: 30% coinsurance Labs: 30% coinsurance X-rays and other imaging tests: 30% coinsurance MRI/CT/PET/NC: 30% coinsurance PT/OT/ST: 30% coinsurance	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$450 PT/OT/ST: \$50	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$450 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 **SDC:** Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

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)
Deductible ¹	IN and OON combined: \$2,700/\$5,400 ³	IN and OON combined: \$4,500/\$9,000	IN and OON combined: \$1,500/\$3,000 ³
Out-of-Pocket Maximum ²	IN and OON combined: \$6,450/\$12,900	IN and OON combined: Medical: \$5,450/\$10,900 Rx: \$1,000/\$2,000	IN and OON combined: \$6,450/\$12,900
Office Visit	IN: Preventive: \$0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: \$25 after deductible Specialist: \$25 after deductible OON: \$45 after deductible	IN: Preventive: \$0 Primary Care: 10% coinsurance after deductible Specialist: 10% coinsurance after deductible OON: 30% coinsurance after deductible (20% coinsurance for preventive care)
Emergency Room	\$150 after deductible	\$150 after deductible	\$150 after deductible
Inpatient Admissions ⁵	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 ⁴	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 ⁵	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: 10% coinsurance after deductible OON: 30% coinsurance after deductible
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 ⁶	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
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**FOOTNOTES LOCATED
ON THE LAST PAGE**

	Preferred Blue [®]		
	Preferred Blue [®] PPO Options v.5 ⁷	Preferred Blue [®] PPO \$1,000 Deductible	Preferred Blue [®] PPO Saver \$1,500 (HSA Compliant)
Deductible ¹	IN: None OON: \$2,000/\$4,000	IN and OON combined: \$1,000/\$2,500	IN and OON combined: \$1,500/\$3,000 ³
Out-of-Pocket Maximum ²	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
Office Visit	IN: Preventive: \$0 EBT: \$15 SBT: \$25 BBT: \$45 Other Network Provider: \$45 OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)
Emergency Room	\$150	\$150 after deductible	\$150 after deductible
Inpatient Admissions ⁵	IN: EBT: \$250 SBT: \$500 (\$300 for select hospitals ⁵) BBT: \$1,000 OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
Surgical Day Care	IN: EBT: \$150 SBT: \$250 BBT: \$500 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 ⁵	IN: EBT: \$75 SBT: \$150 BBT: \$250 Other Network Provider: \$75 OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
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 ⁶	Not Applicable	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/NC: \$450 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 **SDC:** Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

**FOOTNOTES LOCATED
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	Preferred Blue [®]		
	Preferred Blue [®] PPO 80 with Copayment	Preferred Blue [®] PPO \$2,000 Deductible	Preferred Blue [®] PPO Saver \$2,000 (HSA Compliant)
Deductible ¹	IN and OON combined: \$500/\$1,000	IN and OON combined: \$2,000/\$4,000	IN and OON combined: \$2,000/\$4,000 ³
Out-of-Pocket Maximum ²	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
Office Visit	IN: Preventive: \$0 Primary Care: \$20 Specialist: \$20 OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$15 after deductible Specialist: \$15 after deductible OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)
Emergency Room	\$150	\$150 after deductible	\$150 after deductible
Inpatient Admissions ⁵	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 ⁴	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 ⁵	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
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 ⁶	After deductible Inpatient: 30% coinsurance SDC: \$1,250 Labs: 30% coinsurance X-rays and other imaging tests: 30% coinsurance MRI/CT/PET/NC: 30% coinsurance PT/OT/ST: \$55, no deductible	After deductible Inpatient: \$1,000 SDC: \$1,000 MRI/CT/PET/NC: \$450 Labs: \$35 X-rays and 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 **SDC:** Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

**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
Deductible ¹	IN and OON combined: \$2,900/\$5,800 ³	IN: \$2,000/\$4,000 OON: \$4,000/\$8,000	IN: \$2,000/\$4,000 OON: \$4,000/\$8,000
Out-of-Pocket Maximum ²	IN and OON combined: \$6,450/\$12,900	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
Office Visit	IN: Preventive: \$0 Primary Care: Deductible Specialist: Deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: \$65 Specialist: \$65 OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$60 Specialist: \$60 OON: 20% coinsurance after deductible
Emergency Room	\$150 after deductible	\$750 after in-network deductible	35% coinsurance after in-network deductible
Inpatient Admissions ⁵	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	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 ⁵	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
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 Tiers 2 & 3: Retail & Mail: 50% coinsurance OON: Tier 1: Retail: \$30 Mail: Not covered Tiers 2 & 3: Retail: 50% coinsurance Mail: Not covered
Hospital Choice Cost Sharing ⁶	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 **SDC:** Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

**FOOTNOTES LOCATED
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Preferred Blue [®]			
	Preferred Blue [®] PPO Basic Saver (HSA Compliant)	Preferred Blue [®] PPO Basic \$2,000	Preferred Blue [®] PPO Options Deductible II v.5 ⁷
Deductible ¹	IN: \$3,300/\$6,450 ³ OON: \$6,300/\$10,000 ³	IN and OON combined: Medical: \$2,000/\$4,000 Rx: \$250/\$500	IN: EBT: None SBT: \$500/\$1,000 BBT: \$2,000/\$4,000 OON: \$4,000/\$8,000
Out-of-Pocket Maximum ²	IN: \$6,450/\$12,900 OON: \$11,000/\$23,000	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
Office Visit	IN: Preventive: \$0 Primary Care: \$60 after deductible Specialist: \$60 after deductible OON: 20% coinsurance after deductible (no deductible for preventive care)	IN: Preventive: \$0 Primary Care: \$25 Specialist: \$25 OON: 20% coinsurance after deductible	IN: Preventive: \$0 EBT: \$20 SBT: \$35 BBT: \$55 Other Network Provider: \$55 OON: 20% coinsurance after deductible
Emergency Room	\$750 after in-network deductible	\$250	\$250
Inpatient Admissions ⁵	IN: \$1,000 after deductible OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: EBT: \$500 SBT: \$500 after deductible ((\$550 for select hospitals ⁸) BBT: \$1,500 after deductible OON: 20% coinsurance after deductible
Surgical Day Care ⁶	IN: \$1,000 after deductible OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: EBT: \$500 SBT: \$500 after deductible ((\$550 for select hospitals ⁸) BBT: \$1,500 after deductible OON: 20% coinsurance after deductible
MRI, CT, PET Scans, and Nuclear Cardiac Imaging Tests ⁹	IN: \$1,000 after deductible OON: 20% coinsurance after deductible	IN: 20% coinsurance after deductible OON: 40% coinsurance after deductible	IN: EBT: \$75 SBT: \$75 after deductible BBT: \$450 after deductible Other Network Provider: \$75 OON: 20% coinsurance after deductible
Prescription Drugs	IN: Tier 1: Retail: \$15/Mail: \$30 Tier 2 & 3: Retail & Mail: 50% coinsurance OON: Tier 1: Retail: \$30/Mail: Not covered Tier 2 & Tier 3: Retail: 50% coinsurance/Mail: Not covered	IN: Tier 1: Retail: \$15 Mail: \$30 Tiers 2 and 3: Retail & Mail: 50% coinsurance after Rx deductible OON: Tier 1: Retail: \$30 Tiers 2 & 3: Retail: 50% coinsurance after Rx deductible 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 ⁶	Not Applicable	After deductible Inpatient: 30% coinsurance SDC: 30% coinsurance Labs: 30% coinsurance X-rays and other imaging tests: 30% coinsurance MRI/CT/PET/NC: 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 **SDC:** Surgical Day Care **PT/OT/ST:** Physical/Occupational/Speech Therapy

FOOTNOTES LOCATED ON THE LAST PAGE

	Preferred Blue®		
	Preferred Blue® PPO Options Deductible III v.5 ⁷	NEW Preferred Blue® PPO Deductible II	NEW Preferred Blue® PPO Saver II (HSA Compliant)
Deductible ¹	IN: \$2,000/\$4,000 OON: \$4,000/\$8,000	IN and OON combined: \$4,000/\$8,000	IN and OON combined: \$4,000/\$8,000 ⁴
Out-of-Pocket Maximum ²	IN: Medical: \$5,850/\$11,700 Rx: \$1,000/\$2,000 OON: Medical: \$7,500/\$15,000 Rx: \$2,000/\$4,000	IN and OON combined: Medical: \$7,000/\$14,000 Rx: \$1,000/\$2,000	IN and OON combined: \$6,850/\$13,700
Office Visit	IN: Preventive: \$0 EBT: \$20 SBT: \$35 BBT: \$55 Other Network Provider: \$55 OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$25 after deductible Specialist: \$40 after deductible OON: 20% coinsurance after deductible	IN: Preventive: \$0 Primary Care: \$25 after deductible Specialist: \$40 after deductible OON: 20% coinsurance after deductible
Emergency Room	\$250	Deductible	Deductible
Inpatient Admissions ⁵	IN: EBT: Deductible SBT: \$500 after deductible (\$50 after deductible for select hospitals ⁹) BBT: \$1,500 after deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
Surgical Day Care ³	IN: EBT: Deductible SBT: \$500 after deductible (\$50 after deductible for select hospitals ⁹) BBT: \$1,500 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 ⁵	IN: EBT: Deductible SBT: \$75 after deductible BBT: \$450 after deductible Other Network Provider: \$0 OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible	IN: Deductible OON: 20% coinsurance after deductible
Prescription Drugs	IN: Retail: \$15/\$30/\$60/\$120 Mail: \$30/\$60/\$120/\$360 OON: Retail: \$30/\$60/\$120/\$240 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 ⁶	Not Applicable	After deductible Inpatient: \$1,000 SDC: \$1,000 Labs: \$35 X-rays and other imaging tests: \$100 MRI/CT/PET/INC: \$450 PT/OT/ST: \$75	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 SDC: Surgical Day Care PT/OT/ST: Physical/Occupational/Speech Therapy

**FOOTNOTES LOCATED
ON THE LAST PAGE**

Footnotes

1. The two deductible amounts refer to individual and family per plan year unless otherwise noted.
2. The two out-of-pocket maximum amounts refer to individual and family per plan year unless otherwise noted. The out-of-pocket maximum amounts include copayments, coinsurance, and deductible, including costs for covered prescription drugs.
3. Entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.
4. The family deductible can be met through any combination of eligible costs from members on the same family plan. Each member is only responsible for their individual deductible.
5. This is the cost sharing for services rendered at hospitals other than those that are designated as higher cost.
6. Higher cost hospitals are: Baystate Medical Center, Brigham and Women's Hospital, Cape Cod Hospital, Boston Children's Hospital (other than locations at Lexington, Peabody, and Waltham), Dana-Farber Cancer Institute, Fairview Hospital, Massachusetts General Hospital, and UMass Memorial Medical Center – Memorial and University Campuses. This applies to in-network services only.
7. Outside Massachusetts, the lower Enhanced Benefits Tier copayment applies to any network provider who 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.
8. To provide geographic access to members, the lower Standard Benefits Tier copayment applies to Athol Memorial Hospital, Baystate Franklin Medical Center, Berkshire Medical Center, Falmouth Hospital, Martha's Vineyard Hospital, and Nantucket Cottage Hospital.



MASSACHUSETTS