BLUE CHOICE®
NEW ENGLAND
PLAN 2

UNLOCK THE POWER OF YOUR PLAN
MyBlue gives you an instant snapshot of your plan:

- COVERAGE AND BENEFITS
- CLAIMS AND BALANCES
- DIGITAL ID CARD

Sign in
Download the app, or create an account at bluecrossma.com.
Your Primary Care Provider (PCP)

When you enroll in this health plan, you choose a primary care provider (PCP) for you and each member of your family. There are a few ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor; consult the Provider Directory; or call the Member Service number on your ID card. If you have trouble choosing a doctor, Member Service can help. They can give you the doctor’s gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist who is likely affiliated with your PCP’s hospital or medical group. Your provider may also work with Blue Cross Blue Shield of Massachusetts regarding the Utilization Review Requirements including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

When You Choose to Receive Care on Your Own (Self-Referred)

You have the freedom to seek care without seeing your PCP first. When you seek care on your own from a participating provider, your out-of-pocket cost will be greater. If you require hospitalization, you, or someone on your behalf, will need to call us before you’re admitted to make sure that you’re covered.

You must pay a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. The deductible is $750 per member (or $2,500 per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximums are $2,000 per member (or $6,000 per family) for PCP/plan-approved services and $2,500 per member (or $7,500 per family) for self-referred services.

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). You pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

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

Service Area


When Outside the Service Area

If you’re traveling outside the plan’s service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

Dependent Benefits

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

Domestic Partner Coverage

Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.
## Covered Services

### Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost For PCP/Plan-Approved Benefits</th>
<th>Your Cost For Self-Referred Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child care visits</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine vision exams (one per calendar year)</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

### Outpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost For PCP/Plan-Approved Benefits</th>
<th>Your Cost For Self-Referred Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td>$100 per visit (waived if admitted or for observation stay)</td>
<td>$100 per visit, no deductible (waived if admitted or for observation stay)</td>
</tr>
<tr>
<td>Office or health center visits</td>
<td>$25 per visit</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>$25 per visit</td>
<td>20% coinsurance, no deductible*</td>
</tr>
<tr>
<td>Telehealth services for simple medical conditions or mental health</td>
<td>$25 per visit</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Chiropractors’ office visits (up to 18 visits per calendar year)</td>
<td>$25 per visit</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Acupuncture visits (up to 20 visits per calendar year)</td>
<td>$25 per visit</td>
<td>$25 per visit, no deductible*</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy--physical and occupational (up to 60 visits for each type of therapy per calendar year**)</td>
<td>$25 per visit</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment--speech therapy</td>
<td>$25 per visit</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests</td>
<td>$50 per category per service date</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>CT scans, MRIs, PET scans, and nuclear cardiac imaging tests</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Durable medical equipment--such as wheelchairs, crutches, hospital beds</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Surgery and related anesthesia</td>
<td>$25 per visit***</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>• Office or health center services</td>
<td>$100 per admission</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>• Ambulatory surgical facility, hospital outpatient department, or surgical day care unit</td>
<td>$100 per admission</td>
<td>30% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

### Inpatient Care (including maternity care)

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost For PCP/Plan-Approved Benefits</th>
<th>Your Cost For Self-Referred Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>General or chronic disease hospital care (as many days as medically necessary)</td>
<td>$100 per admission</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Mental hospital or substance use facility care (as many days as medically necessary)</td>
<td>$100 per admission</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Rehabilitation hospital care (up to 60 days per calendar year)</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per calendar year)</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

* In addition to your deductible and coinsurance, you may be responsible for any balance of charges above the allowed charge.
** 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.
*** 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.
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: cosmetic surgery; custodial care; most dental care; prescription drugs for use outside of the hospital; 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.

Questions?
For questions about Blue Cross Blue Shield of Massachusetts, call 1-888-389-7732, or visit us online at bluecrossma.com.

Wellness Participation Program
Fitness Reimbursement: a program that rewards participation in qualified fitness programs
This fitness program applies for fees paid to: a health club with cardiovascular and strength-training equipment; a fitness studio offering instructor-led group classes for cardiovascular and strength-training; or virtual fitness memberships or classes. (See your benefit description for details.)

Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program
This weight loss program applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.)

24/7 Nurse Line: A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?
For questions about Blue Cross Blue Shield of Massachusetts, call 1-888-389-7732, or visit us online at bluecrossma.com.
Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

**BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:**

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).

- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscoordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at [ocrportal.hhs.gov](http://ocrportal.hhs.gov); by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at 1-800-368-1019 or 1-800-537-7697 (TDD).

Complaint forms are available at [hhs.gov](http://hhs.gov).
PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：711）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ បានរកបានសប្តាហ៍និងភាសាអត្តគិតថ្លៃ គឺអាចរកបានសប្តាហ៍ការជូនដំណឹងបន្ថែមប់មុនប្រចាំ (TTY: 711)។


Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: 711).


Greek/Ληλινικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλείστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: 711).
Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubiezpieczonych pod numer podany na identyfikatorze (TTY: 711).

Hindi/हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं, तो भाषा सहायता सेवाएं, आप के लिए निःशुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: તમે ગુજરાતી બોલતા છો, તો તમને ભાષાસહાય સહાયકતા સેવાઓ બંંથી ઉપલબ્ધ છે. તમારા આઈ.ડી. કાર્ડ પર આપણા નંબર પર સેવા સેવાઓ ને ટ્રિપલ કરો (TTY: 711).


Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: 711）。


