MASSACHUSETTS | CITY of BOSTON

LEARN ABOUT YOUR BLUE CARE ELECT DEDUCTIBLE PPO PLAN

Find out how your plan works and what the differences are between deductibles, copayments, and co-insurance. Learn what you can expect to pay out-of-pocket for covered services under this plan.

Questions?

If you have any questions about the Blue Care Elect Deductible plan, please call Member Service at **1-888-714-0189**.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

WHICH SERVICES APPLY TO THE DEDUCTIBLE, INCUR A COPAY, OR BOTH.

Type of Service	Deductible ONLY	Copay ONLY	Both Deductible and Copay Apply
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	✓		
OXYGEN AND EQUIPMENT FOR ITS ADMINISTRATION	✓		
HOME HEALTH AND HOSPICE SERVICES	✓		
DIAGNOSTIC X-RAYS AND LAB TESTS	✓		
SPECIALIST OFFICE VISITS		✓	
MENTAL HEALTH OFFICE VISITS		✓	
TELEHEALTH SERVICES		✓	
CHIROPRACTIC VISITS		✓	
SHORT-TERM REHABILITATION VISITS, INCLUDING PHYSICAL THERAPY, SPEECH THERAPY, AND OCCUPATIONAL THERAPY		✓	
SURGERY PERFORMED IN AN OFFICE SETTING		✓	
HIGH-TECH RADIOLOGY (CT SCANS, PET SCANS, MRIs AND NUCLEAR CARDIAC IMAGING)			✓
EMERGENCY ROOM VISITS			✓
SURGERY PERFORMED AT A HOSPITAL OR OUTPATIENT SURGERY CENTER			✓
HOSPITAL ADMISSIONS (NOT INCLUDING MENTAL HOSPITALS OR SUBSTANCE USE DISORDER FACILITIES)			✓
REHABILITATION HOSPITAL CARE			✓
SKILLED NURSING FACILITIES			✓

UNDERSTANDING YOUR BLUE CARE ELECT DEDUCTIBLE PLAN

When you get care anywhere in the United States, you'll be covered by your Blue Care Elect Deductible plan. This plan covers primary care provider visits, telehealth (online) care, specialty care, prescription medication, hospital visits, and more. Before you get care, it's important to understand the difference between in-network and out-of-network care, when you'll have to pay for care, what services are covered, and if you have any visit limitations.

This Is a Preferred Provider Organization (PPO) Plan

With this plan:

1. You can visit any doctor or hospital for covered services
2. In-network care will typically cost less than out-of-network care
3. You don't need a referral to see a specialist

What's the Difference Between In-Network and Out-of-Network Care?

When you get care from an in-network doctor or hospital, you'll pay less for care because these providers have agreed to participate in your network.

If you see an out-of-network doctor or provider, you'll pay the most out-of-pocket costs because these providers don't participate in your network, and will charge you their full fee for services.

What Is Prior Authorization?

Certain services and medications must be approved as medically necessary before coverage begins. This ensures that you don't pay more than you have to for unnecessary care. If a service or medication requires prior authorization, your doctor must request it before being performed or prescribed.

Some services that require prior authorization include sleep management programs, hospital stays, MRIs, CT scans, genetic testing, and certain medications.

Important Terms to Know

Copayment—Also called a copay, this is the fixed amount you pay at the time of service, for some types of care.

Deductible—The amount you pay for some types of health care services before your plan covers eligible expenses. Each plan year, your deductible resets on July 1.

Co-insurance—The percentage of the cost you're responsible for paying for covered services out-of-network, usually after the deductible has been met Your plan pays the rest, excluding balance billing.*

Out-of-pocket Maximum—The most you'll pay per plan year for covered health care services before your plan pays 100 percent of the costs.

Preventive Care

Getting preventive care is one of the most important steps you can take to stay healthy. Preventive care is covered at no cost to you. Other screenings, such as mammograms and colonoscopies, are also covered at 100 percent.

You Need to Pay for Diagnostic Care

Diagnostic care includes services you receive when you're experiencing symptoms, or you're monitoring a specific condition. You're responsible for paying any out-of-pocket costs, such as a copayment, co-insurance, or costs that go toward your deductible, for any such care associated with such a service.

*Balance billing occurs when an out-of-network provider sends a bill for the difference between their cost of service, and the amount that your plan pays for that service.

Questions?

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