

## Rider

# Hospital Choice Cost Sharing Feature

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This *rider* modifies the terms of your health plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

Your health plan option includes a tiered network cost sharing feature called Hospital Choice Cost Sharing. Your health plan ID card shows “Hospital Choice Cost Sharing Feature” when your health plan includes this tiered network cost sharing feature. **With this feature, your cost share level for general hospitals that participate in your health plan’s provider network will differ depending on the network general hospital you choose to furnish your *covered services*.** For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive *covered services* from any of the network general hospitals listed below in this *rider*, you pay the highest cost sharing level. The network general hospitals listed in this Hospital Choice Cost Sharing *rider* may change from time to time. Any changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. *Blue Cross Blue Shield HMO Blue* will let you (or your *group* when you are a *group member*) know before changes will become effective for your health plan option. For help in finding a network general hospital (not listed below in this *rider*) for which you pay the lowest cost sharing level, check in the most current provider directory for your health plan option or visit the online provider search tool at [www.bluecrossma.com](http://www.bluecrossma.com).

### Network Hospitals in the Highest Cost Sharing Benefits Level

The cost share amount that you must pay for general hospital services will depend on which network general hospital you choose to furnish the *covered service*. **Your cost share amount will usually be higher when you receive *covered services* at any one of the network general hospitals as listed below.**

- Baystate Medical Center
- Boston Children’s Hospital
- Brigham & Women’s Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- UMass Memorial Medical Center

**Special Note:** Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply. For information on the locations and which cost sharing level applies, check in the most current provider directory for your health plan option or visit the online provider search tool at [www.bluecrossma.com](http://www.bluecrossma.com).

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### **A network general hospital's cost sharing level may change from time to time.**

The network general hospitals listed in this Hospital Choice Cost Sharing *rider* may change from time to time. *Blue Cross Blue Shield HMO Blue* will let you (or your *group* when you are a *group member*) know before changes will become effective for your health plan option. If you are in your second or third trimester of pregnancy or if *Blue Cross Blue Shield HMO Blue* is aware you are terminally ill, you will be sent a notice when the network general hospital where you receive your care is changed to the highest cost sharing level. The notice will be sent to you at least 30 days before the change and it will explain how to find a different network general hospital for continued treatment.

### **Cost share Amounts for Hospitals in the Highest Cost Sharing Benefits Level**

#### **(1) Inpatient Admissions**

For *inpatient* admissions in any one of the network hospitals listed above, you must pay a *copayment* for each admission. Your *inpatient copayment* for these network hospitals will be calculated as the total of the amount (excluding any *deductible*) you would normally pay for an admission in any other network general hospital not listed above plus \$1,000. The only exception is for admissions for *inpatient emergency medical care*. For an *inpatient* admission directly from the emergency room, the lowest hospital *copayment* amount will apply. (If a *deductible* normally applies to hospital admissions, this *copayment* is in addition to the *deductible*.)

#### **(2) Outpatient Day Surgery**

For *outpatient* day surgery furnished at any one of the network hospitals listed above, you must pay a *copayment* for each admission. Your day surgery *copayment* for these network hospitals will be calculated as the total of the amount (excluding any *deductible*) you would normally pay for a day surgery admission in any other network general hospital not listed above plus \$1,000. (If a *deductible* normally applies to day surgery admissions, this *copayment* is in addition to the *deductible*.)

#### **(3) Outpatient Diagnostic Lab Tests**

For *outpatient diagnostic lab tests* that are furnished by any one of the network hospitals listed above, you must pay a *copayment* for each date of service. Your *copayment* for these *covered services* will be calculated as the total of the amount (excluding any *deductible*) you would normally pay when *outpatient diagnostic lab tests* are furnished by any other network general hospital not listed above plus \$35. The *copayment* does not apply to interpretation costs. (If a *deductible* normally applies to these *covered services*, this *copayment* is in addition to the *deductible*.)

#### **(4) Outpatient Advanced Imaging Tests**

For *outpatient* diagnostic CT scans, MRIs, PET scans, and nuclear cardiac imaging tests that are furnished by any one of the network hospitals listed above, you must pay a *copayment* for each category of test for each date of service. Your *copayment* for these *covered services* will be calculated as the total of the amount (excluding any *deductible*) you would normally pay when these covered imaging tests are furnished by any other network general hospital not listed above plus \$450. The *copayment* does not apply to interpretation costs. (If a *deductible* normally applies to these *covered services*, this *copayment* is in addition to the *deductible*.)

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**(5) Outpatient Diagnostic X-Rays and Other Imaging Tests**

For *outpatient* diagnostic x-rays and imaging tests other than those described in (4) above that are furnished by any one of the network hospitals listed above, you must pay a *copayment* for each date of service. Your *copayment* for these *covered services* will be calculated as the total of the amount (excluding any *deductible*) you would normally pay when these *covered services* are furnished by any other network general hospital not listed above plus \$100. The *copayment* does not apply to interpretation costs. (If a *deductible* normally applies to these *covered services*, this *copayment* is in addition to the *deductible*.)

**(6) Outpatient Short-Term Rehabilitation Therapy**

For *outpatient* short-term rehabilitation therapy (physical, occupational, and speech/language therapy) that is furnished by any one of the network hospitals listed above, you must pay a *copayment* for each visit. Your *copayment* for these *covered services* will be calculated as the total of the amount (excluding any *deductible*) you would normally pay when *outpatient* short-term rehabilitation therapy is furnished by any other network general hospital not listed above plus \$35. (If a *deductible* normally applies to these *covered services*, this *copayment* is in addition to the *deductible*.)

For the amount you must pay for other network hospitals not listed above, see your Subscriber Certificate.

All other provisions remain as described in your Subscriber Certificate.