MASSACHUSETTS

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Effective: 7/1/2024

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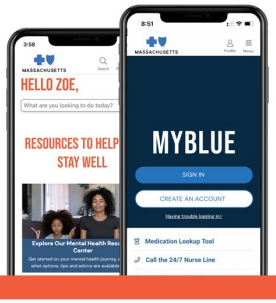
UNDERSTANDING YOUR PLAN AND BENEFITS



YOUR PLAN IN YOUR HAND

Get an instant snapshot of your health care.

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BlueCross® BlueShield®

SUMMARY OF BENEFITS

BLUE CARE ELECT $250 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

City of Brockton

Plan-Year Deductible: $250/$500

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.org.**

Where you get care can impact what you pay for care.

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.
As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the preferred general hospitals listed in this Summary of Benefits, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital (not listed in this Summary of Benefits for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CHOICE

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan.A If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$250** per member (or **$500** per family) for in-network and out-of-network services combined.

When You Choose Preferred Providers
You receive the highest level of benefits under your health care plan whenA you obtain covered services from preferred providers. These are called your "in-network" benefits. See the charts for your cost share.A

The plan has two levels of hospital benefits for preferred providers. You will payA a higher cost share when you receive inpatient services at or by "higher cost share hospitals," even if your preferred provider refers you. See the chart for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

Higher Cost Share Hospitals
Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

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

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost share may apply.

How to Find a Preferred Provider
To find a preferred provider:A

- Look up a provider on Find a Doctor at **bluecrossma.com/findadoctor**. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.

- Visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**

When You Choose Non-Preferred Providers
You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits.A See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue ShieldA allowed charge as defined in your benefit description. You may be responsibleA for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$1,200** per member (or **$2,400** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **$5,400** per member (or **$10,800** per family).

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 in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Utilization Review Requirements
Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includesA non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible forA payment to the provider of the service. Refer to your benefit description forA requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

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

Well-child care exams, including routine tests, according to age-based schedule as follows: • Ten visits during the first year of lifeA • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing, no deductible	20% coinsurance after deductible
	Nothing, no deductible	20% coinsurance after deductible
	Nothing, no deductible	20% coinsurance after deductible
	Nothing, no deductible	Nothing, no deductible
	Nothing, no deductible	20% coinsurance after deductible
	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visitsA	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$100 per visit, no deductible (waived if admitted or for an observation stay)	$100 per visit, no deductible (waived if admitted or for an observation stay)
• A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care	$20 per visit, no deductible	20% coinsurance after deductible
	$25 per visit, no deductible	20% coinsurance after deductible
	$20 per visit, no deductible	20% coinsurance after deductible
	Same as in-person visit $20 per visit, no deductible	Same as in-person visit Only applicable in-network
	$20 per visit, no deductible	20% coinsurance after deductible
	$25 per visit, no deductible	20% coinsurance after deductible
	$20 per visit, no deductible	20% coinsurance after deductible
	$20 per visit, no deductible	20% coinsurance after deductible
	Nothing after deductible	20% coinsurance after deductible
	$100 per category per service date after deductible	20% coinsurance after deductible
	Nothing after deductible	20% coinsurance after deductible
	Nothing after deductible	20% coinsurance after deductible
	20% coinsurance after deductible**	40% coinsurance after deductible**
	20% coinsurance after deductible	40% coinsurance after deductible
• A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care	$20 per visit***, no deductible	20% coinsurance after deductible
	$25 per visit***, no deductible	20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care) in:		
• Other general hospitals (as many days as medically necessary) • In-network higher cost share hospitals (as many days as medically necessary)	$150 per admission after deductible† $450 per admission after deductible†	20% coinsurance after deductible Only applicable in-network
Chronic disease hospital care (as many days as medically necessary)	$150 per admission after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$150 per admission after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible

* 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.
** In-network cost share waived for one breast pump per birth, including supplies (20% coinsurance after deductible out-of-network).
*** 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.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*A		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**A	No deductible $10 for Tier 1 $25 for Tier 2 $45 for Tier 3	Not covered
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**A	No deductible $20 for Tier 1 $50 for Tier 2 $90 for Tier 3	Not covered

*A Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.A
** Cost share may be waived or reduced for certain covered drugs and supplies.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitnessA programs or equipment (See your benefit description for details.)A	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualifiedA weight loss program (See your benefit description for details.)A	$150 per calendar year per policy
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)A	$300 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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; 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.A

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see **www. .com**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **bluecrossma.org/sbcglossary** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 member / $500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, prescription drugs; emergency room.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, $1,200 member / $2,400 family; and for prescription drug benefits, $5,400 member / $10,800 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care; a telehealth cost share may be applicable
	Specialist visit	$25 / visit; $20 / chiropractor visit; $25 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; cost share waived for at least one mental health wellness exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	$100	20% coinsurance	Deductible applies first; copayment applies per category of test / day; pre-authorization may be required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or $50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$45 / retail supply or $90 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	20% coinsurance	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 / visit; deductible does not apply	$100 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$25 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 / admission; $450 / admission for certain hospitals	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$150 / admission; $450 / admission for certain hospitals	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$150 / admission; $450 / admission for certain hospitals	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first except for in-network outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth, including supplies (20% coinsurance for out-of-network)
	Hospice services	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% coinsurance for members with a cleft palate / cleft lip condition	Deductible applies first for out-of-network; limited to members under age 18

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in network prenatal care and a hospital delivery)

■ The plan's overall deductible	$250
■ Delivery fee copay	$0
■ Facility fee copay	$150
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$510**

Managing Joe's Type 2 Diabetes
(a year of routine in network care of a well controlled condition)

■ The plan's overall deductible	$250
■ Specialist visit copay	$25
■ Primary care visit copay	$20
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in network emergency room visit and follow up care)

■ The plan's overall deductible	$250
■ Specialist visit copay	$25
■ Emergency room copay	$100
■ Ambulance services copay	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

MASSACHUSETTS

MCC COMPLIANCE

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

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This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from some preferred general hospitals, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospitalA for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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MASSACHUSETTS

PREFERRED BLUE® PPO WITH HOSPITAL CHOICE COST SHARING

IMPORTANT INFORMATION ABOUT YOUR PLAN

Your health plan lets you get care from providers who participate in the **Blue Cross Blue Shield PPO Network with Hospital Choice Cost Sharing**, as well as from providers who are out of our network. You'll pay a lower cost for care when you see an in-network provider, and a higher cost when you see an out-of-network provider.

This plan has a Hospital Choice Cost Sharing feature, which means you'll pay different costs depending on where you receive certain services.*

HOW TO ACCESS IMPORTANT RESOURCES

We're committed to your health — that's why we offer additional programs, benefits, and discounts beyond traditional health care coverage. Use these tools and resources to monitor your health and overall wellness.

Unlock the Power of Your Plan: MyBlue is your key to managing your plan. Use it to track your claims, medications, account balances, and more. Download the MyBlue app, or create an account at **bluecrossma.org**.

Let Team Blue Lend a Hand: Your health plan comes with a special feature: a coordinated team, ready to spring into action whether you need help understanding your coverage or getting care. Need answers, access, or advice? Just ask. Call **1-800-262-2583**.

Get Exclusive Health and Wellness Deals: Blue365® offers great discounts and deals on sportswear, nutrition, travel, fitness equipment, and more. Explore available deals atA **blue365deals.com**.

Need to Find a Doctor?

1. Go to **bluecrossma.org**. 2. Click **Find a Doctor** under **Find Care**.
3. Enter a provider or type of care, then select **PPO Network with Hospital Choice Cost Sharing**.

*Members pay different costs (copayments, co-insurance, and deductibles) depending on the benefits tier of the general hospital furnishing the services, and the type of service being provided. A hospital's tier may change; however, overall changes to the tiers of providers will happen no more than once each calendar year. To determine a hospital's tier, use the **Find a Doctor** tool.

ACCESSING CARE

The Importance of Receiving In-Network Care: To pay the lowest cost, you should see in-network doctors. You can also see out-of-network doctors, but you'll pay higher out-of-pocket costs. When selecting a doctor, consider the hospital where that doctor has admitting privileges. You can use the **Find a Doctor** tool to look up this information.

Routine Health Checkups: You don't have to choose a primary care provider (PCP) to help manage your care. However, routine health checkups with your PCP are one of the best ways you can stay on top of your health.

Seeing a Specialist: If you need to see a specialist, you don't need a referral from your PCP. However, you should talk with your doctor about the specialty care you may need.

Telehealth Visits: When appropriate, you can choose to have phone or video visits with covered medical and mental health care providers. Ask your provider if they offer telehealth.

24/7 Nurse Line: Speak to a registered nurse, right when you need to, day or night. Call **1-888-247-BLUE (2583)**.

UNDERSTANDING PRIOR AUTHORIZATION

To make sure you only get care that's medically necessary and covered by your plan, your doctor needs to obtain prior authorization, or approval, from us for certain services, procedures, or medications. Without prior authorization, your care may not be covered, and you may have to pay the full cost. Be sure to ask your doctor if prior authorization is needed before you receive care.

ABOUT YOUR ID CARD

You need to show your member ID card when you go to the doctor or a hospital. It includes important details, such as copay amounts and your member ID number.† If you have pharmacy coverage, this will be noted, too. You can use the MyBlue app to view, download, and email a digital version of your card.

Lost your ID card?
No problem, you can order another one through MyBlue.

†As of January 1, 2022, your ID card also includes information about the maximum deductible and out-of-pocket costs for your plan.A

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BlueCross® BlueShield®

SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND $250 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

City of Brockton

Plan-Year Deductible: $250/$500

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.org.**

Where you get care can impact what you pay for care.

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.
As a member in this plan, you will pay different levels of cost share (such as copayments and/or coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from any of the network general hospitals listed in this Summary of Benefits, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital (not listed in this Summary of Benefits) for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CARE

Your Primary Care Provider (PCP)
When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**; consult Find a Doctor at **bluecrossma.com/findadoctor**; 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 the doctor attended, and whether there are languages other than English spoken in the office.A

Referrals
Your PCP is the first person you call when you need routine or sick care. If yourA 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 yourA PCP's hospital or medical group.

You will not need prior authorization or referral to see an HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and 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.A

Your Cost Share
This plan has two levels of hospital benefits. You will pay a higher cost share whenA you receive inpatient services at or by "higher cost share hospitals," even if your PCP refers you. See the chart for your cost share.

Higher Cost Share Hospitals
Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

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

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

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.

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan.A If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$250** per member (or **$500** per family).

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$1,200** per member (or **$2,400** per family). Your out-of-pocket maximum for prescription drug benefits is **$5,400** per member (or **$10,800** per family).

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're admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Service Area
The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area
If you're traveling outside the 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. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.A

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visitsA	Nothing, no deductible
Outpatient Care	
Emergency room visits	$100 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits, when performed by:A • Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit, no deductible $25 per visit, no deductible
Mental health or substance use treatment	$20 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit $20 per visit, no deductible
Chiropractors' office visitsA	$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	$25 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by:A • Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit***, no deductible $25 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible
Inpatient Care (including maternity care) in:	
• Other general hospitals (as many days as medically necessary) • Higher cost share hospitals (as many days as medically necessary)	$150 per admission after deductible† $450 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	$150 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$150 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

* 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.
** Cost share waived for one breast pump per birth, including supplies.
*** 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.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
Prescription Drug Benefits*A	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**A	No deductible $10 for Tier 1 $25 for Tier 2 $45 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**A	No deductible $20 for Tier 1 $50 for Tier 2 $90 for Tier 3

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived or reduced for certain covered drugs and supplies.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitnessA programs or equipment (See your benefit description for details.)A	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualifiedA weight loss program (See your benefit description for details.)A	$150 per calendar year per policy
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)A	$300 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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; 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.A

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see **www. .com**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **bluecrossma.org/sbcglossary** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 member / $500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, prenatal care, emergency room, prescription drugs, most office visits, mental health visits, and therapy visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, $1,200 member / $2,400 family; and for prescription drug benefits, $5,400 member / $10,800 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	A telehealth cost share may be applicable
	Specialist visit	$25 / visit; $20 / chiropractor visit; $25 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$100	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or $50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$45 / retail supply or $90 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit; deductible does not apply	$100 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$25 / visit	$25 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 / admission; $450 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	A telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$150 / admission; $450 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$150 / admission; $450 / admission for certain hospitals	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	Not covered	Deductible applies first except for outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$20 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Deductible applies first; cost share waived for one breast pump per birth, including supplies
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in network prenatal care and a hospital delivery)

■ The plan's overall deductible	$250
■ Delivery fee copay	$0
■ Facility fee copay	$150
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$510**

Managing Joe's Type 2 Diabetes
(a year of routine in network care of a well controlled condition)

■ The plan's overall deductible	$250
■ Specialist visit copay	$25
■ Primary care visit copay	$20
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in network emergency room visit and follow up care)

■ The plan's overall deductible	$250
■ Specialist visit copay	$25
■ Emergency room copay	$100
■ Ambulance services copay	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

MASSACHUSETTS

MCC COMPLIANCE

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

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This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of cost share (such as copayments and coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from some network general hospitals, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital for which you pay the lowest cost sharing level,A check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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HMO BLUE NEW ENGLAND

IMPORTANT INFORMATION ABOUT YOUR PLAN

Your health plan lets you get care from providers who participate in the **HMO Blue New England Network**. Under this plan, you're required to choose a primary care provider (PCP) to manage your care and refer you to specialists.

HOW TO ACCESS IMPORTANT RESOURCES

We're committed to your health—that's why we offer additional programs, benefits, and discounts beyond traditional health care coverage. Use these tools and resources to monitor your health and overall wellness.

Unlock the Power of Your Plan: MyBlue is your key to more features and savings. Plus, you can track your claims, medications, account balances, and more. To create an account, go to **bluecrossma.org** or download the MyBlue app.

Let Team Blue Lend a Hand: Your health plan comes with a special feature: a coordinated team, ready to spring into action whether you need help understanding your coverage or getting the care you need. Need answers, access, or advice? Just ask. Call **1-800-262-2583**.

Get Exclusive Health and Wellness Deals: Blue365® offers great discounts and deals on sportswear, nutrition, travel, fitness equipment, and more. Explore available deals atA **blue365deals.com**.

Need to Find a Doctor?

Go to **bluecrossma.org** to use the **Find a Doctor** tool. To search for an in-network doctor, specialist, or hospital near you, select the network: **HMO Blue New England**.

ACCESSING CARE

The Importance of a Primary Care Provider: Routine health checkups with your PCP are one of the best ways you can stay on top of your health. Your PCP can also manage your care and refer you to specialists.

Choose a PCP for yourself and every member of your family covered under your plan. Everyone doesn't need to see theA same PCP.

When selecting a PCP, consider the hospital where your PCP has admitting privileges. You can use the **Find a Doctor** tool to find this information.A

Seeing a Specialist: If you need to see a specialist, your PCP must refer you for the care to be covered under your plan. Make sure your PCP has contacted the specialist's office and provided the referral.A

Telehealth Visits: When appropriate, you can choose to have phone or video visits with covered medical and mental health care providers. Ask your provider if they offer telehealth.

24/7 Nurse Line: Speak to a registered nurse, right when you need to, day or night. Call **1-888-247-BLUE (2583)**.

UNDERSTANDING PRIOR AUTHORIZATION

To make sure you only get care that's medically necessary and covered by your plan, your doctor needs to obtain prior authorization, or approval, from us for certain services, procedures, or medications. Without prior authorization, your care may not be covered, and you may have to pay the full cost. Be sure to ask your doctor if prior authorization is needed before you receive care.

ABOUT YOUR ID CARD

You need to show your member ID cardA when you go to the doctor or a hospital. It includes important details, such as copay amounts and your member ID number.* If you have pharmacy coverage,A this will be noted, too. You can use the MyBlue app to view, download, and email a digital version of your card.

Lost your ID card?A
No problem, you can order another one through MyBlue.

*As of January 1, 2022, your ID card will also include information aboutA the maximum deductible and out-of-pocket costs for your plan.A

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.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).A
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**).A
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**).A

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MASSACHUSETTS

SUMMARY OF BENEFITS

DENTAL BLUE® FREEDOM

City of Brockton

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.org.**

DENTAL BLUE FREEDOM

Preventive Benefit GroupA	Basic Benefit GroupA	Major Benefit GroupA
No Deductible		
Full Coverage*	80% Coverage*	50% Coverage*
$2,000 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)A		

Diagnostic
- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- Bitewing X-rays twice per calendar year
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams twice per calendar year
- Emergency exams

Preventive
- Routine cleaning, scaling, and polishing of the teeth twice per calendar year
- Fluoride treatment twice per calendar year (members under age 19)
- Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per bicuspid or molar surface each 48 months.
- Space maintainers needed due to premature tooth loss (members under age 19)

Restorative
- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period)
- Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery
- Tooth extraction
- Root removal
- Biopsies

Periodontics (gum and bone)A
- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)A
- Root canal therapy (permanent teeth, once in a lifetime per tooth)
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- Other endodontic surgery to treat or remove the dental root

Prosthetic Maintenance
- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- Adding teeth to an existing complete or partial denture
- Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Services
- Occlusal adjustments once each 24 months
- Services to treat root sensitivity
- General anesthesia when administered in conjunction with covered surgical services
- Emergency dental care to treat acute pain or to prevent permanent harm to a member

Prosthodontics (teeth replacement)A
- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- Adding teeth to an existing bridge
- Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)

Major Restorative (members age 16 or older)A
- Crowns, once each 60 months for each tooth
- Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Post and core or crown buildup, once each 60 months for each tooth

Implants (members age 16 or older)A
- Single tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars

* Benefits are reduced by 20 percent when services are received from an out-of-network dentist.

WELCOME TO DENTAL BLUE FREEDOM,

A DENTAL PLAN DESIGNED TO MANAGE THE COST OF DENTAL SERVICES.

Your Dentist
Dental Blue Freedom offers a large network of dentists, including participating dentists in Massachusetts and nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

If you would like help choosing a dentist, or already have a dentist and want to know if they participate with your plan, you can call the dentist, look at the current dental provider directory, or call Member Service at the toll-free phone number shown on your Dental Blue ID card. You can also access the online dental provider directory at **bluecrossma.org**.

Your BenefitsA
You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

The dental benefits your plan covers are subject to the coinsurance (if applicable) and calendar-year benefit maximum amounts shown in the chart. The calendar year begins on January 1 and ends on December 31 of each year. The chart also shows the percentage of costs your plan will pay for covered dental services. Many of the covered services have specific time or age limits.

Pre-Treatment Estimates
If your dentist expects that your dental treatment will involve covered services that will cost more than $250, Blue Cross Blue Shield recommends that your dentist send a copy of the "treatment plan" to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service. Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year benefit maximum or eligibility status has changed.)

Multi-Stage Procedures
Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure. You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Network Dentists Are Paid – Preferred DentistsA
For dentists who have a preferred provider contract with Blue Cross Blue Shield, benefits are calculated based on the provisions of the preferred dentist's payment agreement and the dentist's allowed charge that is in effect at the time the covered dental service is provided. Preferred dentists agree to accept the allowed charge as payment in full. You pay your coinsurance (if applicable) and any allowed charges beyond your calendar-year benefit maximum.

How Network Dentists Are Paid – Participating DentistsA
For dentists who participate with Blue Cross Blue Shield, but do not have a Blue Cross Blue Shield preferred provider contract, benefits are calculated at the same benefit level that applies when the same covered dental services are provided by a preferred dentist. These dentists agree to accept the allowed charge as payment in full. You pay your coinsurance (if applicable) and any allowed charges beyond your calendar-year benefit maximum.

How Out-of-Network Dentists Are Paid – Non-Preferred or Non-Participating DentistsA
Benefits for covered services by a non-preferred or non-participating dentist are provided based on the allowed charge or the dentist's actual charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your coinsurance (if applicable) and charges beyond your calendar-year benefit maximum.

When Coverage Begins
You are covered, without a waiting period, from the date you enroll in the plan.

Dependent BenefitsA
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 plan description (and riders, if any) for exact coverage details.

Accumulated Maximum Rollover BenefitsA
This dental plan includes an Accumulated Maximum Rollover Benefit. This rollover benefit allows you to roll over a certain dollar amount of your unused annual dental benefits for use in the future. There are limits and restrictions on this benefit. Refer to the Accumulated Dental Maximum Rollover brochure for further information.

Enhanced Dental BenefitsA
Enhanced Dental Benefits for certain dental care services are available for members who have been diagnosed with qualifying conditions. To learn more about specific conditions included in this benefit, review your plan description (and riders, if any) on MyBlue at **bluecrossma.org**.

If You Have to File a ClaimA
Network dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist as long as the claims are received within one year of the completed service.

If you receive care from an out-of-network dentist, you will typically need to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service.

After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

If you have a grievance, see your plan description for instructions on how to file a grievance.

Other InformationA
Coordination of benefits applies to plan members who are covered by another plan for health care expenses. Coordination of benefits ensures that payments from other insurance or health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause, which means that Blue Cross Blue Shield can recover payments if a member has already been paid for the same claim by a third party.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

At Blue Cross Blue Shield of Massachusetts, we know that oral health is a critical part of overall health. That's why we offer a dental benefit that will allow you to roll over a portion of your unusedA dental benefits from year to year.A

HOW MAXIMUM ROLLOVER WORKS

Beginning 60 days after the last day of your benefit period, your rollover amount will be added to your maximum benefit amount, increasing it for you to use that year and beyond (see below for amounts and maximums).

There is no cost to you. You don't need to do anything.A To figure out the amount of benefit dollars that are eligibleA to roll over, just use the chart below. Start by searching forA your benefit period maximum in the first column. If Blue CrossA doesn't pay out more claims dollars on your behalf than theA amount in the second column, your benefit maximum for theA next year will increase by the amount in the third column.A

And, your rollover amount keeps growing and is available for you to use as long as your employer offers this rollover benefit.* The last column will show you the total amount of additional benefit dollars you can earn. It's one more way we're working to improve health care for all our members.A

You can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures.A
This benefit applies to you automatically if:A

- You receive at least one service during the benefit periodA
- You remain a member of the plan throughout the benefit periodA
- You don't exceed the claim payment threshold in theA benefit periodA

If your dental plan's annual maximum benefit amount is:	And if your total claims don't exceed this amount for the benefit period:*A	We'll roll over this amount for you to use next year and beyond:*A	However, rollover totals will be capped at this amount:*A
$500–$749	$200	$150	$500
$750–$999	$300	$200	$500
$1,000–$1,249A	$500	$350	$1,000A
$1,250–$1,499A	$600	$450	$1,250A
$1,500–$1,999A	$700	$500	$1,250A
$2,000–$2,499A	$800	$600	$1,500A
$2,500–$2,999A	$900	$700	$1,500A
$3,000 or moreA	$1,000A	$750	$1,500A

*This is not a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.A

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MASSACHUSETTS

SUMMARY OF BENEFITS

MEDEX® 2

City of Brockton

This Medex plan provides benefits for:A
• Medicare Part A and B Deductibles and CoinsurancesA
• OBRA BenefitsA

This Medex plan does not provide benefits for:A
• Prescription DrugsA

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

Sign in

Download the app, or create an account at **bluecrossma.org.**

QUESTIONS? CALL 800-258-2226. (TTY) 711.

The Member Service staff can assist you Monday through Friday, 8 a.m. to 6 p.m.
Medicare Office Telephone Number in Massachusetts: **1-800-MEDICARE (1-800-633-4227)**

This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance; however, the Commonwealth of Massachusetts has stated that enrollment in Original Medicare (Medicare Part A and Medicare Part B) satisfies these standards.A

YOUR MEDICAL BENEFITS

	Medicare Provides	Medex Provides
Inpatient Care		
Hospital care—including surgical services, X-rays and lab tests, anesthesia, drugs and medications, and intensive care services	• Coverage for days 1–60 per benefit period after Part AA deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†
Physician or other professional provider services	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance
Skilled nursing facility—participating with Medicare*	• Full coverage for days 1–20 • Coverage for days 21–100 after daily Part A coinsurance	• Full coverage of Medicare daily coinsurance for days 21–100 • $16 daily for days 101–365
Skilled nursing facility—not participating with Medicare*	No benefitsA	$16 daily for 365 days per benefit periodA
Outpatient Care		
Office visits, emergency services,A surgery, radiation therapy, X-ray and lab tests, podiatrists' services, durable medical equipment, and cardiac rehabilitation services	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance
Blood glucose monitors and materials to test for the presence of blood sugar	80% of approved charges after annual Part B deductible for all diabetics	Full coverage of Medicare deductible and coinsurance
Urine test strips (Claims must be submitted on a Medex Subscriber Claim form)	No benefitsA	Full coverage based on the allowed charge
Chiropractor services	80% of approved charges after annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray	Full coverage of Medicare deductible and coinsurance for Medicare-approved charges only
Short-term rehabilitation – physical therapy, speech-pathology, and occupational therapy services approved by Medicare	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance

	Medicare Provides	Medex Provides
Mental Health and Substance Use Treatment		
Biologically based mental conditions**		
Inpatient admissions in a general or mental hospital	• Coverage for days 1–60 per benefit period after Part AA deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance • Coverage for mental hospital admissions is limited to a 190 day lifetime maximum	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†
Outpatient visits	80% of approved charges after annual Part B deductible	• When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When visits are not covered by Medicare, full coverage with no visit maximum
Non-biologically based mental conditions		
Inpatient admissions in a general hospital	• Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to a 190 day lifetime maximum	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • When Medicare benefits areA used up, full coverage up to 120 days per benefit period (at leastA 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)†
Outpatient visits	80% of approved charges after annual Part B deductible	• When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year

† The additional days are a combination of days in a general or mental hospital.
*A A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.A
** Treatment of rape-related mental or emotional disorders for victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

Preventive Services Approved by Medicare and Medex

Medicare provides coverage for certain preventive services at no cost to members. For the current list of covered preventive services, refer to your Medicare & You handbook or go to **medicare.gov**. Some preventive covered services are highlighted below.

- One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)
- One routine flexible sigmoidoscopy every fourA years for members age 50 or older (Full coverage for tests)
- One routine colonoscopy every two years for a high-risk member (Full coverage for tests)
- Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare (Full coverage for tests)
- Routine prostate cancer screening for members 50 or older including one (PSA) test and one digital rectal exam, per calendar year (Full coverage for exam if doctor accepts assignment, full coverage for PSA test)
- One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)
- One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)
- One baseline mammogram during the five year period a member is age 35-39A and one routine mammogram per calendar year for members age 40 and older (Full coverage for screening)
- One routine Pap smear test per calendar year (Full coverage for test)

Important Information

- The Medicare deductible and coinsurance amounts are subject to change January 1 of each year.
- Benefits are available immediately upon your effective date.A
- Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.

Limitations and Exclusions. These pages summarize your health care plan. Your plan description and riders define the full terms and conditions. Should any questionsA arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.A

November 2023

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MASSACHUSETTS

HOSPITAL CHOICE COST SHARING

Your medical plan gives you an opportunity to control your share of medical costs for hospital care. What you pay depends on the hospital or related facility you choose.

LOWER COST SHARE

Lower Cost Share ($) applies to hospitals and related facilities that have met our quality benchmarks and are lower in cost. You pay less when you get care at these hospitals.

HIGHER COST SHARE

Higher Cost Share ($$) applies to hospitals and related facilities that are higher in cost.. You pay more when you get care at these hospitals.

HOW HOSPITAL CHOICE COST SHARING WORKS

These costs apply to inpatient care, outpatient day surgery, outpatient high-tech radiology, outpatient diagnostic lab tests, outpatient diagnostic X-rays and other imaging tests, and outpatient short-term rehabilitation therapy.

This guide can help you get the highest value from your plan. Just follow the simple steps on the next page to review your hospitals and your options. Your health benefits will tell you what your specific share of the costs is. If you're not sure,A you can call Member Service at the number on the front of your member ID card.A

Questions?

If you have any questions about your benefits, call Member Service at the number on the front of your ID card.A

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you'll pay different levels of cost share* (such as copayments and/or co-insurance) for certain services depending on the network* general hospital you choose to furnish those covered services. For most network general hospitals, you'll pay the lowest cost sharing level. However, if you receive certain covered services from some network general hospitals, you pay the highest cost-sharing level. A network general hospital's cost-sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost-sharing level will happen no more than once each calendar year. For help in finding a network general hospital for which you pay the lowest cost-sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **myplans.bluecrossma.com/medical-insurance/hospital-choice-cost-sharing**. Then click the Planning Guide link on the left of the screen to download a printable network hospital list, or to access the provider search page.

FOLLOW THESE THREE SIMPLE STEPS

Step 1: Make a List of the Hospitals Where You Receive Care

In the table below, list all the hospitals and clinics where you and your family go for care. Be sure to check which hospitals your doctors are affiliated with whenyou make your list.

Step 2: Find Out What You'd Pay at the Hospitals Where You Receive Care

Finding out whether your hospitals have a Lower or Higher Cost Share is easy:

- Visit the Hospital Choice Cost Sharing website at **myplans.bluecrossma.com/medical-insurance/hospital-choice-cost-sharing**.
- Review the hospital list included with this document to check your hospitals.
- Call to **1-888-636-4808**. Our specially trained Member Service associates are ready to help you review your current hospitals.

Step 3: Choose Hospitals with a Lower Cost Share

If you go to Higher Cost Share hospitals, you might consider switching to Lower Cost Share hospitals. This will allow you to pay less every time you get care.

We can help you quickly and easily pick Lower Cost Share hospitals near where you live or work. Call Member Service at **1-888-636-4808**. You can also use our hospital search at the Hospital Choice Cost Sharing website: **myplans.bluecrossma.com/medical-insurance/hospital-choice-cost-sharing**.

If you have any questions about your benefits, call Member Service at the number on the front of your ID card.

HOSPITAL LIST

Hospital Name	City	State	Member Cost Share
Addison Gilbert Hospital	Gloucester	MA	Lower
Anna Jaques Hospital	Newburyport	MA	Lower
Athol Memorial Hospital	Athol	MA	Lower
Baystate Franklin Medical Center	Greenfield	MA	Lower
Baystate Medical Center	Springfield	MA	Higher
Berkshire Medical Center	Pittsfield	MA	Lower
Beth Israel Deaconess Hospital—Milton	Milton	MA	Lower
Beth Israel Deaconess Hospital—Needham Campus	Needham	MA	Lower
Beth Israel Deaconess Hospital—Plymouth	Plymouth	MA	Lower
Beth Israel Deaconess Medical Center	Boston	MA	Lower
Beverly Hospital	Beverly	MA	Lower
Boston Children's Hospital	Boston	MA	Higher
Boston Children's at Lexington	Lexington	MA	Lower
Boston Children's at Peabody	Peabody	MA	Lower
Boston Children's at Waltham	Waltham	MA	Lower

Continued

Hospital Name	City	State	Member Cost Share
Boston Medical Center	Boston	MA	Lower
Brigham and Women's Hospital	Boston	MA	Higher
Brigham and Women's/Mass General Health Care Center at Patriot Place	Foxborough	MA	Lower
Cambridge Health Alliance—Cambridge Campus	Cambridge	MA	Lower
Cambridge Health Alliance—Somerville Campus	Somerville	MA	Lower
Cambridge Health Alliance—Whidden Campus	Everett	MA	Lower
Cape Cod Hospital	Hyannis	MA	Higher
Carney Hospital	Dorchester	MA	Lower
Clinton Hospital	Clinton	MA	Lower
Cooley Dickinson Hospital	Northampton	MA	Lower
Dana-Farber Cancer Institute	Boston	MA	Higher
Emerson Hospital	Concord	MA	Lower
Fairview Hospital	Great Barrington	MA	Higher
Falmouth Hospital	Falmouth	MA	Lower
Faulkner Hospital	Jamaica Plain	MA	Lower
Good Samaritan Medical Center	Brockton	MA	Lower
Harrington Memorial Hospital	Southbridge	MA	Lower
HealthAlliance Hospitals—Burbank Campus	Fitchburg	MA	Lower
HealthAlliance Hospitals—Leominster Campus	Leominster	MA	Lower
Heywood Hospital	Gardner	MA	Lower
Holy Family Hospital	Methuen	MA	Lower
Holy Family Hospital at Merrimack Valley	Haverhill	MA	Lower
Holyoke Medical Center	Holyoke	MA	Lower
Lahey Clinic	Burlington	MA	Lower
Lawrence General Hospital	Lawrence	MA	Lower
Lawrence Memorial Hospital	Medford	MA	Lower
Lowell General Hospital (includes the campus formerly known as Saints Medical Center)	Lowell	MA	Lower
Marlborough Hospital	Marlborough	MA	Lower
Martha's Vineyard Hospital	Oak Bluffs	MA	Lower
Massachusetts Eye and Ear® Infirmary	Boston	MA	Lower
Massachusetts General Hospital	Boston	MA	Higher
Mass General/North Shore Center for Outpatient Care	Danvers	MA	Lower
Melrose-Wakefield Hospital	Melrose	MA	Lower
Mercy Medical Center	Springfield	MA	Lower
MetroWest Medical Center—Framingham Union	Framingham	MA	Lower
MetroWest Medical Center—Leonard Morse	Natick	MA	Lower
Milford Regional Medical Center	Milford	MA	Lower
Morton Hospital and Medical Center	Taunton	MA	Lower

Continued

Hospital Name	City	State	Member Cost Share
Mount Auburn Hospital	Cambridge	MA	Lower
Nantucket Cottage Hospital	Nantucket	MA	Lower
Nashoba Valley Medical Center	Ayer	MA	Lower
New England Baptist®˝ Hospital	Boston	MA	Lower
Newton-Wellesley Hospital	Newton	MA	Lower
Noble Hospital	Westfield	MA	Lower
North Shore Medical Center—Salem Campus	Salem	MA	Lower
North Shore Medical Center—Union Campus	Lynn	MA	Lower
Norwood Hospital	Norwood	MA	Lower
Saint Vincent Hospital	Worcester	MA	Lower
Shriners Hospitals for Children—Boston	Boston	MA	Lower
Shriners Hospitals for Children—Springfield	Springfield	MA	Lower
Signature Healthcare Brockton Hospital	Brockton	MA	Lower
South Shore Hospital	South Weymouth	MA	Lower
Southcoast Hospitals Group—Charlton Memorial Hospital	Fall River	MA	Lower
Southcoast Hospitals Group—St. Luke's Hospital	New Bedford	MA	Lower
Southcoast Hospitals Group—Tobey Hospital	Wareham	MA	Lower
Southwestern Vermont Medical Center	Bennington	VT	Lower
St. Anne's Hospital	Fall River	MA	Lower
St. Elizabeth's Medical Center	Brighton	MA	Lower
Sturdy Memorial Hospital	Attleboro	MA	Lower
The Vernon Cancer Center at Newton-Wellesley	Newton	MA	Lower
Tufts Medical Center	Boston	MA	Lower
UMass Memorial Medical Center—Memorial Campus	Worcester	MA	Higher
UMass Memorial Medical Center—University Campus	Worcester	MA	Higher
Winchester Hospital	Winchester	MA	Lower
Wing Memorial Hospital	Palmer	MA	Lower

MASSACHUSETTS

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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**).
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**).

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MASSACHUSETTS

DOCTORS ON CALL, ON YOUR DEVICE.

Get convenient access to telehealth care by using Well Connection. Sign in to MyBlue, or create an account, then click Well Connection Video Visit under My Care.

REAL DOCTORS. REAL EXPERIENCE. REALLY FAST.

GET MEDICAL CARE 24/7

Speak face to face with a doctor, in the privacy of your home.[1]

THERAPY THAT COMES TO YOU

Talk to a licensed therapist or psychiatrist—on your terms. It's convenient and confidential.

HIGHLY EXPERIENCED, HIGHLY RATED

Qualified providers. Rated 4.8/5 stars and averaging 15 years of experience.[2]

Sign In

Download the MyBlue App from the App Store®´ or Google Play™, or go to **bluecrossma.org**.

1. Medical services are available 24/7. Mental health visits must be made by appointment. If your local doctor in the Blue Cross Blue Shield of Massachusetts network offers covered services using live video visits through a service other than Well Connection, you're still covered. This service is only available in the United States.

2. Source: American Well. Amwell Telehealth Report, February 2018. Patient Satisfaction Survey Data compiled December 2017-February 2018. Data, compiled December 2017-February 2018. Data reverified, August 2020.

IS A VIDEO DOCTOR VISIT RIGHT FOR ME?

You can do a lot over your tablet, laptop, or smartphone. Here's how members are using this service.

"I'm not feeling well."

Get care for:

- Cold and flu symptoms
- Fever
- Runny nose, sinus pain
- Sore throat
- Pink eye
- Skin rash

"I need emotional support."

Talk to a therapist about:

- Depression and anxiety
- Substance use disorder
- Loss of a loved one
- Relationship issues
- Emotional trauma
- Stress

You can also schedule a visit with a psychiatrist for medication management services.

"My loved one is under the weather."

If they're on your plan:

- Get quick, expert family care
- Save time in your busy family schedule

WELL CONNECTION IS HIGHLY RATED:

4.8 out of 5 Doctor and Provider rating from our members[3]

Licensed doctors and providers in the Well Connection network have an average of 15 years of experience. They can look up your medical history, diagnose and treat your symptoms, and prescribe medication,[4] if necessary.

3. Source: American Well. AmWell TeleHealth Report, February 2018. Patient Satisfaction Survey Data, compiled December 2017-February 2018. Data reverified, August 2020.

4. Prescription availability is defined by doctor judgment.

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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**).
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**).

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MASSACHUSETTS

LEARN ABOUT TIERS

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FORMULARY

The following information explains our tiered pharmacy plans with the Blue Cross Blue Shield of Massachusetts formulary (list of covered medications), and how those tiers determine the cost of your medications.

Our formulary includes a range of generic and brand-name medications, which are placed into tiers. Your out-of-pocket costs will depend on your plan benefits and the tier of your medication.

HOW TIERS DETERMINE WHAT YOU PAY FOR MEDICATIONS

Our list of covered medications is based on a tiered cost structure. When you fill a prescription, the amount you pay the pharmacy is determined by your medication's tier and your benefits. The amount you pay may also include your copayment, co-insurance, and deductibles. The pharmacist will tell you what you owe at checkout. To find your out-of-pocket costs in advance, download the MyBlue app, or create an account at **bluecrossma.org**. Once signed in, click **Price a Medication** under **My Medications**.

HOW COVERED MEDICATIONS ARE PLACED INTO TIERS

Medications are placed into tiers according to a variety of factors, including what they're used for, their cost, and whether equivalent or alternative medications are available. Lower-tier medications typically cost less than higher-tier medications. For example, in a 3-tier structure, you'll likely pay the least for Tier 1 medications and the most for Tier 3 medications.

Pharmacy plans can use one of the five different tier structures outlined in this document. Check your plan materials to see which tier structure your plan uses, and to learn more about how medications are covered.[1]

Learn more about your coverage

For more information about your pharmacy benefits, sign in to MyBlue at **bluecrossma.org**.

1. Exceptions may apply. For example, the brands and preferred brands tiers could include some generic medications in addition to brand-name medications.

OUR TIER STRUCTURES

2-TIER	
Tier 1: Generics	Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same Food & Drug Administration (FDA) requirements.
Tier 2: Brands	Brand-name medications cost more than generic medications, so you'll **pay more** if you use them.

3-TIER	
Tier 1: Generics	Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same FDA requirements.
Tier 2: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
Tier 3: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred brands.

4-TIER	
Tier 1: Preferred generics	These medications are preferred because they cost less than other generic medications.
Tier 2: Non-preferred generics	Non-preferred generic medications cost more than preferred generics, so you'll **pay more** if you use them instead of preferred generics.
Tier 3: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
Tier 4: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred brands.

(continued)

5-TIER	
Tier 1: Generics	Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same FDA requirements.
Tier 2: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
Tier 3: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred brands.
Tier 4: Preferred brand specialty	These specialty medications are preferred because they're safe, effective alternatives to more expensive, brand-name specialty medications.
Tier 5: Non-preferred brand specialty	Non-preferred brand-name specialty medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred brand-name specialty medications.

6-TIER	
Tier 1: Preferred generics	These medications are preferred because they cost less than other generic medications.
Tier 2: Non-preferred generics	Non-preferred generic medications cost more than preferred generics, so you'll **pay more** if you use them instead of preferred generics.
Tier 3: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
Tier 4: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred brands.
Tier 5: Preferred brand specialty	These specialty medications are preferred because they're safe, effective alternatives to more expensive, brand-name specialty medications.
Tier 6: Non-preferred brand specialty	Non-preferred brand-name specialty medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred brand-name specialty medications.

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**; 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**.

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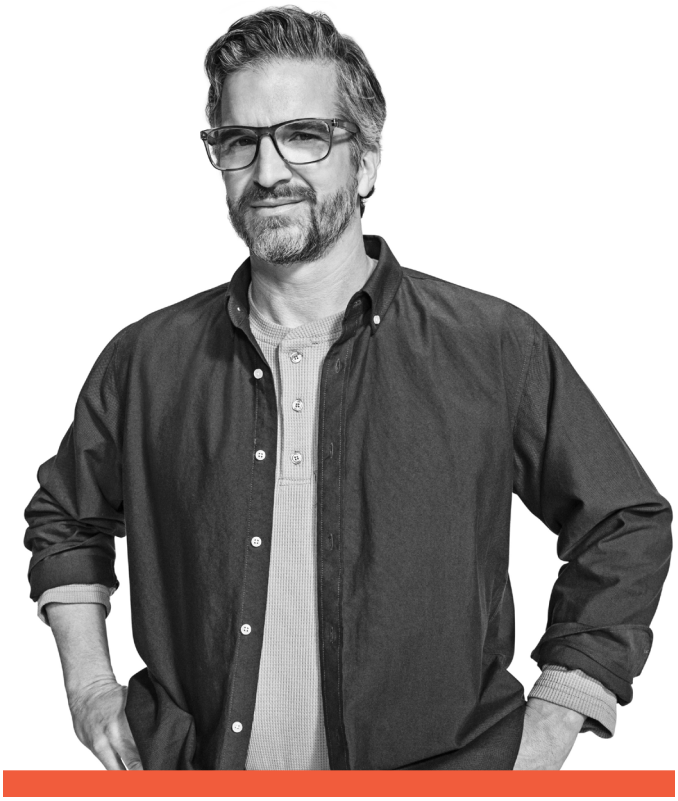
MASSACHUSETTS

SAVE TIME AND MONEY WITH MAINTENANCE CHOICE VOLUNTARY

Maintenance Choice Voluntary saves you 33% on the cost of your maintenance medications,[1] also known as long-term medications, when you switch to a 90-day supply and fill your prescriptions at a retail pharmacy that participates in the Maintenance Choice Voluntary program, or through the mail service pharmacy.[2]



SWITCHING BRINGS BENEFITS

Pay 33% less for 90-day supplies of most maintenance medications.

Enjoy the convenience of filling medications at any of the 9,000+ retail pharmacies that participate in the Maintenance Choice Voluntary program.

Pay $0 for standard delivery through the mail service pharmacy.

Make fewer trips to the pharmacy, or none at all.

EXAMPLE OF HOW YOU CAN SAVE[3]

Type of prescription	Medication copay		
	Tier 1	Tier 2	Tier 3
30-day supply, retail pharmacy	$15	$30	$50
90-day supply, participating retail pharmacy or mail service pharmacy	$30	$60	$150

1. In most cases for eligible maintenance medications. Check plan materials for more details.
2. Maintenance Choice Voluntary isn't available in Oklahoma and West Virginia. If you're a resident of these states, you can still save money on your medications when you fill them in 90-day supplies at an in-network pharmacy that is able to dispense medications in 90-day supplies.
3. For illustrative purposes only, using a 3-tier plan.

(Continued)

HOW TO SWITCH TO 90-DAY FILLS

Participating retail pharmacy

Talk to your health care provider about switching to a 90-day prescription, or show the pharmacist one of the emails you receive about switching to 90-day fills.

To find a participating pharmacy:

1 Download the MyBlue app or create an account at **bluecrossma.org**.

2 Once signed in, click **Find a Pharmacy** under **My Medications**, then look for a pharmacy that offers 90-day supplies.

Mail service pharmacy

1 Download the MyBlue app or create an account at **bluecrossma.org**.

2 Once signed in, click **90-Day Mail Service Pharmacy** under **My Medications**.

STAY CONNECTED

To make sure you receive emails about the Maintenance Choice Voluntary program, update your communication preferences in MyBlue:

1 Download the **MyBlue app** or create an account at **bluecrossma.org**.

2 Once signed in, click **Pharmacy Benefit Manager** under **My Medications**.

3 Go to **Profile**.

4 Select **Communication preferences** and enter your **email address**.

Questions?

If you have any questions, call CVS Customer Care at **1-877-817-0477** (TTY: **711**).

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MASSACHUSETTS

Last updated: January 1, 2024

NO-COST GENERIC MEDICATIONS

MEDICATION LIST

For plans that use the:

Blue Cross Blue Shield of Massachusetts Formulary

UNLOCK THE POWER OF YOUR PLAN

MyBlue is your key to more features and savings. Once you sign in or create an account, you can see all of your benefits, all in one place, such as:

COVERAGE, CLAIMS, AND DEDUCTIBLES

REIMBURSEMENTS AND SAVINGS

FIND A DOCTOR & ESTIMATE COSTS

MEDICATION LOOKUP

Download the MyBlue app or create an account at **bluecrossma.org.**

GENERIC MEDICATIONS THAT ARE COVERED AT NO COST

The following list includes medications that are covered at no cost for eligible members who have one or more of the following conditions: depression, high cholesterol, diabetes, heart disease, and high blood pressure. The copay and deductible will be waived for these medications when purchased at an in-network retail pharmacy, or through the mail service pharmacy. You should talk with your doctor first to ensure that these medications are right for you.

This isn't a complete list of covered medications, and inclusion on this list doesn't guarantee coverage.[1] You must have a valid prescription from a licensed health provider to receive coverage for these medications. Some medications may also be subject to pharmacy management programs, such as step therapy, prior authorization, or quality care dosing, or have other coverage requirements.

NOTE: Some medications on this list may be considered non-covered, including new medications under review by Blue Cross. Your doctor may request an exception for a non-covered medication when medically necessary.[2]

Learn more about your coverage

For more information about coverage for these medications, sign in to MyBlue at **bluecrossma.org** or open the MyBlue app, then go to **Medication Lookup Tool** under **My Medications**.

If you're not a member, you can get more information by visiting **bluecrossma.org/medication**.

1. Not all medications listed are covered by all prescription plans. Check your benefit materials for details.
2. If approved, you'd pay the highest-tier cost.

MEDICATION CLASS	MEDICATION NAME
Antidepressants	FLUOXETINE 10MG CAP
	FLUOXETINE 20MG CAP
Antidiabetics	METFORMIN HYDROCHLORIDE 500MG TABS
	METFORMIN HYDROCHLORIDE 850MG TABS
	METFORMIN HYDROCHLORIDE 1000MG TABS
Antihyperlipidemics	ATORVASTATIN CALCIUM 10MG TAB
	ATORVASTATIN CALCIUM 20MG TAB
	ATORVASTATIN CALCIUM 40MG TAB
	ATORVASTATIN CALCIUM 80MG TAB
	SIMVASTATIN 5MG TAB
	SIMVASTATIN 10MG TAB
	SIMVASTATIN 20MG TAB
	SIMVASTATIN 40MG TAB
	SIMVASTATIN 80MG TAB
Antihypertensives	LISINOPRIL 2.5MG TAB
	LISINOPRIL 5MG TAB
	LISINOPRIL 10MG TAB
	LISINOPRIL 20MG TAB
	LISINOPRIL 30MG TAB
	LISINOPRIL 40MG TAB
	LOSARTAN POTASSIUM 25MG TAB
	LOSARTAN POTASSIUM 50MG TAB
	LOSARTAN POTASSIUM 100MG TAB
Beta blockers	ATENOLOL 25MG TAB
	ATENOLOL 50MG TAB
	ATENOLOL 100MG TAB
	METOPROLOL SUCCINATE ER 25MG 24HR TAB
	METOPROLOL SUCCINATE ER 50MG 24HR TAB
	METOPROLOL SUCCINATE ER 100MG 24HR TAB
	METOPROLOL SUCCINATE ER 200MG 24HR TAB
	METOPROLOL SUCCINATE SR 25MG 24HR TAB

(continued)

MEDICATION CLASS	MEDICATION NAME
Beta blockers (continued)	METOPROLOL SUCCINATE SR 50MG 24HR TAB
	METOPROLOL SUCCINATE SR 100MG 24HR TAB
	METOPROLOL SUCCINATE SR 200MG 24HR TAB
Calcium channel blockers	AMLODIPINE BESYLATE 2.5MG TAB
	AMLODIPINE BESYLATE 5MG TAB
	AMLODIPINE BESYLATE 10MG TAB
Diuretics	FUROSEMIDE 20MG TAB
	FUROSEMIDE 40MG TAB
	FUROSEMIDE 80MG TAB
	HYDROCHLOROTHIAZIDE 12.5MG CAP
	HYDROCHLOROTHIAZIDE 12.5MG TAB
	HYDROCHLOROTHIAZIDE 25MG TAB
	HYDROCHLOROTHIAZIDE 50MG TAB
	HYDROCHLOROTHIAZIDE 100MG TAB

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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**).

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MASSACHUSETTS

SAVE MONEY ON YOUR MEDICATIONS WITH THE MAIL SERVICE PHARMACY

Maintenance medications, also known as long-term medications, are used to treat chronic or ongoing conditions. Save 33% when you order them in 90-day supplies through the mail service pharmacy.[1]

BENEFITS OF USING THE MAIL SERVICE PHARMACY

You'll pay 33% less for 90-day supplies of most maintenance medications (that's one less copay).

There's no additional cost for standard delivery.

Signing up for automatic refills makes it less likely to miss a dose.

EXAMPLE OF HOW YOU'LL SAVE[2]

TYPE OF PRESCRIPTION	MEDICATION COPAY		
	Tier 1	Tier 2	Tier 3
30-day supply, retail pharmacy	$15	$30	$50
90-day supply, mail service pharmacy	$30	$60	$150

1. In most cases for eligible maintenance medications. Check plan materials for more details.
2. For illustrative purposes only, using a 3-tier plan.

(continued)

HOW TO USE THE MAIL SERVICE PHARMACY

Download the MyBlue app or create an account at **bluecrossma.org**. Once signed in, click **Pharmacy Benefit Manager** under **My Medications,** then go to the **Prescriptions** tab. To:

TRANSFER PRESCRIPTIONS

Click
Start Rx Delivery by Mail

ORDER REFILLS

Click
View/Refill All Prescriptions

SET UP AUTOMATIC REFILLS

Click
Manage Automatic Refills

You can also fill prescriptions by calling CVS Customer Care at **1-877-817-0477** (TTY: **711**), or by using the included order form.

WHY ISN'T MY MEDICATION AVAILABLE THROUGH THE MAIL SERVICE PHARMACY?

Certain medications that require immediate administration or are used for short periods of time aren't available through the mail service pharmacy. In addition, some specialty medications are only available through specialty pharmacies.

Please Note:

Certain prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions about your medication, call CVS Customer Care at **1-877-817-0477** (TTY: **711**).

It's the patient's responsibility to report any changes in drug allergies, health conditions, chronic diseases, and drug sensitivities.

Prescription information about members and dependents is used to administer your prescription program. That information is reported to Blue Cross Blue Shield of Massachusetts, and is used for reporting and analysis, without identifying individual patients in accordance with applicable laws.

Questions?

If you have any questions, call CVS Customer Care at **1-877-817-0477** (TTY: **711**).

MASSACHUSETTS

CVS caremark®

Mail Service Order Form

Mail this form to:

CVS Caremark
PO BOX 659541
SAN ANTONIO, TX 78265-9541

Member ID # (if not shown or if different from above)

Prescription Plan Sponsor or Company Name

Please fold here →

Instructions:

Please use **blue or black ink** and **print in capital letters.** Fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at **bluecrossma.org**. Go to **90-Day Mail Service** under **My Medications**.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name | First Name | MI | Suffix (JR, SR)

Street Address | Apt./Suite #

○ **Use shipping address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1) 2) 3) 4)

5) 6) 7) 8)

CVS Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

CaremarkPCS Health, LLC ("CVS Caremark") is an independent company that has been contracted to administer pharmacy benefits and provide certain pharmacy services for Blue Cross Blue Shield of Massachusetts. CVS Caremark is part of the CVS Health family of companies. Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.

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C **Tell us about the people ordering prescriptions.** If there are more than two people, please complete another form.

First person with a refill or new prescription. ○ Spanish forms and labels

Last Name | First Name | MI | Suffix (JR,SR)

Nickname | Date of birth: MM-DD-YYYY

E-mail address: | Date new prescription written:

Doctor's last name | Doctor's first name | Doctor's phone #

Tell us about new health information for 1st person if never provided or if changed.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other:

Medical conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid reflux ○ Glaucoma ○ Heart problem ○ High blood pressure ○ High cholesterol ○ Migraine ○ Osteoporosis ○ Prostate issues ○ Thyroid ○ Other:

Second person with a refill or new prescription. ○ Spanish forms and labels

Last Name | First Name | MI | Suffix (JR,SR)

Nickname | Date of birth: MM-DD-YYYY

E-mail address: | Date new prescription written:

Doctor's last name | Doctor's first name | Doctor's phone #

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other:

Medical conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid reflux ○ Glaucoma ○ Heart problem ○ High blood pressure ○ High cholesterol ○ Migraine ○ Osteoporosis ○ Prostate issues ○ Thyroid ○ Other:

D **Special instructions:**

E **How would you like to pay for this order?** (If your copay is $0, you do not need to provide payment information.)

○ **Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

○ **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

○ Use your card on file.

○ Use a new card or update your card's expiration date.

Exp.Date MMYY

Credit card holder signature/Date

○ **Check or money order.** Amount: $.

- Make check or money order payable to CVS Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to $40.

Payment for Balance Due and Future Orders: If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

○ Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

○ **2nd business day ($17)**

○ **Next business day ($23)**

Faster delivery can only be sent to a street address, not a PO Box

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor

(Charges subject to change)

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MASSACHUSETTS

DENTAL BLUE®
GOOD ORAL HEALTH LEADS TO BETTER OVERALL HEALTH

The connection is clear: Patients who take care of their teeth and visit a dentist regularly tend to be in better overall health. For example, the treatment of periodontal disease may help control blood sugar levels in diabetics; cut the risk of delivering a preterm, low-birthweight baby; and limit the severity of heart disease.[1]

HOW HEALTHY IS YOUR MOUTH?

Answer this questionnaire to find out.		
1. Do you brush your teeth less than once per day and floss less than several times per week?	Yes	No
2. Do your gums bleed when you brush your teeth?	Yes	No
3. Has it been longer than a year since your last dental visit?	Yes	No
4. Are you diabetic?	Yes	No
5. Have you had more than two fillings placed in the past two years?	Yes	No
6. Do you prefer eating sweets to eating fruits and vegetables?	Yes	No
7. Do you take medications that may cause a dry mouth?	Yes	No
8. Do you smoke and/or have more than two alcoholic drinks per day?	Yes	No

A higher number of "Yes" answers to these questions may mean you're at greater risk of developing oral health problems, which can impact your overall health and make controlling certain conditions more difficult.

Schedule Your Regular Dental Checkup

You can search for in-network dentists using our Find a Doctor tool at **bluecrossma.com/findadoctor**.

(Continued)

WHY IT'S IMPORTANT

The questions on page 1 call attention to important habits that can keep your mouth healthy, and identify risk factors that can lead to poor oral health. Following these habits and recognizing the warning signs can help you stay healthy.

HOW ORAL HEALTH AFFECTS CERTAIN CONDITIONS

Your oral health can affect health conditions, such as:

- **Heart Disease—**Researchers have linked increased bacteria in oral plaque to the increase of the same bacteria in arteries leading to the heart.[1]
- **Diabetes—**People with diabetes, especially when it's uncontrolled, are more likely to have periodontal disease than those without the condition, and periodontal disease can increase blood sugar.[2]
- **Pregnancy—**Pregnant women with periodontal disease are more likely to give birth to premature babies.[3]

HOW DENTAL BLUE HELPS

Our Dental Blue plans give you the tools, resources, and comprehensive coverage to help keep your mouth healthy. As a member, you enjoy:

- Preventive visits to the dentist at no cost to you*
- Access to one of the largest dental networks nationwide
- Enhanced Dental Benefits

*Check your plan benefits for details.

HEALTHY HABITS

Following these habits can improve your oral health and reduce your risk of periodontal disease, tooth decay, and oral cancer:

- Brush your teeth twice per day and floss daily.
- Visit the dentist regularly.
- Eat a well-balanced diet.
- Avoid smoking and having more than two alcoholic drinks per day.

RISK FACTORS

Being aware of these risk factors can help you prevent or manage an oral health problem:

- Bleeding gums
- Diabetes
- Frequent fillings or crowns
- Taking medications that reduce saliva

ENHANCED DENTAL BENEFITS

Our condition-specific total health solution helps members with qualifying medical conditions, such as those listed above, manage their oral and overall health. We identify members who may benefit from oral health interventions and provide additional, specific support, including full coverage for preventive and non-surgical periodontal services that have been connected to improved overall health.

To see if you qualify for Enhanced Dental Benefits, call Member Service at the number on the front of your ID card.

1. American Academy of Periodontology, "New Reports Confirm Perio-Systemic Connection and Outline Clinical Recommendations," perio.org, 2019.
2. Ibid., "Diabetes and Periodontal Disease," 2019.
3. Ibid., "Expectant Mothers' Periodontal Health Vital to Health of Her Baby," 2019.

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MASSACHUSETTS

DENTAL BLUE® QUICK-START GUIDE

For Large Employer Groups

Thank you for choosing Dental Blue. This guide will help you get the most from your plan by providing you with a summary of common benefits and services, as well as a general understanding of how your dental coverage works. For specific details about the benefits available to you, refer to your subscriber certificate.

If you have any questions, call Team Blue at the Member Service number on the front of your ID card.

How Dental Plans Work

Basic plans help offset the cost of diagnostic and preventive dental care. More comprehensive plans may also cover a percentage of restorative care. Most plans limit the benefit expenses per calendar year (or per lifetime, in the case of orthodontic benefits).

What You Should Know Before Visiting a Dentist

Which Plan Do You Have?

Our plans include Dental Blue®, Dental Blue® PPO, Dental Blue® Select, Dental Blue® Freedom, and Dental Blue® Value. Refer to your benefit summary, or sign in to MyBlue at **bluecrossma.org** to view your plan details.

If You Have a Deductible or Co-insurance

You may be responsible for some of the costs for services. Knowing your deductible and co-insurance amounts will help you understand what you have to pay.

If You Qualify for Enhanced Dental Benefits

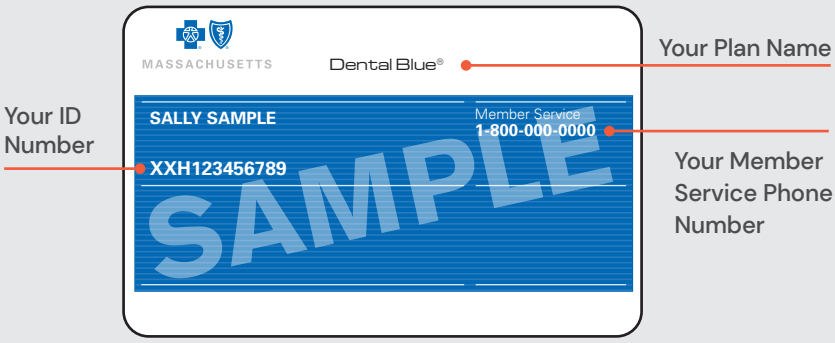
See page 3 for more information about the program.

Know How to Read Your ID Card

Your Dental Blue ID card contains important information like our Member Service phone number and your ID number. Be sure to always carry your ID card with you, and show it to all of your providers, so they can keep your records up to date.

Get Your Digital ID Card

MyBlue gives you digital access to your ID cards, so you can easily use it from your computer or mobile device. Download the MyBlue app or create an account at **bluecrossma.org**.



OUR PLANS

Dental Blue

Our traditional dental plan offers flexible dental coverage across a large network of dental providers. When you receive services from in-network dentists, you'll see lower rates, and pay lower out-of-pocket costs.

Dental Blue PPO

You'll get better rates for services when you see one of the dentists in the Dental Blue PPO network. If you go out-of-network, you're still covered, but you'll have to pay higher out-of-pocket costs.

Dental Blue Select

Similar to our PPO plan, you'll get better rates for services when you see one of the dentists in the Dental Blue PPO network. There's a deductible for out-of-network preventive services, and you won't be charged for preventive services after the deductible is met.

Dental Blue Freedom

Dental Blue Freedom offers the largest selection of network dentists. You'll get the best rates for in-network care, especially when you see dentists in the Dental Blue PPO network. If you go out-of-network, you're still covered, but you'll pay the highest out-of-pocket costs for service.

Dental Blue Value

Our standard Table of Allowance plan offers coverage across a large network of dental providers. When you see an in-network dentist, you're responsible for the difference between the Dental Blue Value Table of Allowance amount and our contracted provider's fee schedule.

Our Networks

Dental Blue

Our traditional network offers access to more than 98 percent of dentists in Massachusetts.

Dental Blue PPO

You'll receive the most coverage when you see one of the thousands of dentists in Massachusetts who participate in our PPO network.

Nationwide Network Access

Plan Name	Network Coverage			
	Dental Blue	Dental Blue PPO	Nationwide Network Access	Out-of-Network Providers
Dental Blue	•		•	*
Dental Blue PPO		•	•	•
Dental Blue Select		•	•	•
Dental Blue Freedom	•	•	•	•
Dental Blue Value	•	•	•	•

*Refer to your subscriber certificate to see if you have out-of-network options.

Filing Your Claims

If Your Dentist Files the Claim

Most participating dentists will send your claims to us. We'll pay them directly if we receive the claim within two years of the completed service.

If Your Dentist Doesn't File the Claim

If your dentist doesn't file the claim, which may occur when you visit a non-participating dentist, download our dental claim form at **bluecrossma.org**, complete it, and mail it to:

Blue Cross Blue Shield of Massachusetts
Dental Operations
P.O. Box 986030
Boston, MA 02298

Manage Your Dental Budget: Tips to Help You Plan for Any Out-of-Pocket Costs

Show Your Dental Blue ID Card Every Time You See a Dentist

This will ensure that your claims are filed properly.

Find Out What You Owe for Each Visit

Some plans require you to pay a deductible or co-insurance.

Know Your Benefit Maximum

Once you reach the calendar-year limit and use any additional accumulated maximum rollover benefit, no more services will be covered until the following year.

Monitor the Balance of Your Benefit Maximum

Team Blue can help you keep an eye on your account balances. Call the Member Service number on the front of your ID card.

Visit Dentists in Our Network

You'll receive the most coverage when you visit dentists who participate in our network.

QUESTIONS?

If you have any questions, call Team Blue at the Member Service number on the front of your ID card, Monday through Friday, 8:00 a.m. to 6:00 p.m. ET (TTY: **711**)

GET THE MOST FROM YOUR PLAN

Enhanced Dental Benefits

Dental Blue offers the only condition-specific total health solution with a complete program for at-risk members with qualifying medical conditions. Our Enhanced Dental Benefits offer additional, specific support, including full coverage for preventive and periodontal services that have been connected to improved overall health. To learn more about specific conditions included in this benefit, review your subscriber certificate on MyBlue at **bluecrossma.org**.

Accumulated Maximum Rollover

Some plans allow you to roll over a portion of your unused dental benefits from year to year. This can help offset higher out-of-pocket costs for complex procedures. To find out if you have this benefit, sign in to MyBlue at **bluecrossma.org**.

MyBlue

MyBlue is your online member account that gives you instant digital access to your plan benefits, tools and resources. Track your claims, view your digital member ID card, and get answers to your questions. To get started, download the MyBlue app or create an account at **bluecrossma.org**.

Find a Doctor or Dentist

Our **Find a Doctor & Estimate Costs** tool makes it easy for you to find what you need.

- Search for doctors, dentists, hospitals, and other health care providers
- Read and write reviews
- Compare up to 10 doctors at a time

To start searching, download the MyBlue app or sign in at **bluecrossma.org**, then select **Find a Doctor & Estimate Costs** under **My Care**.

FREQUENTLY ASKED QUESTIONS

Q: I only received two Dental Blue ID cards. How do I get additional cards for my family?

A: You can order replacement and/or additional ID cards online through MyBlue at **bluecrossma.org**. You can also call Member Service at the number on the front of your ID card.

Q: How do I find a dentist or specialty dental provider who is participating with my dental plan?

A: You can use our **Find a Doctor & Estimate Costs** tool at **bluecrossma.com/findadoctor** to search for dentists and other specialty providers that participate in your plan. Sign in to your MyBlue account for the best results, or continue without signing in by choosing your current dental plan.

Q: Do all Dental Blue members have nationwide network access?

A: Yes, all dental members have access to 500,000 credentialed provider locations nationwide. To find a dentist, visit **bluecrossma.com/findadoctor**.

Q: Where do I find my specific dental coverage information?

A: You can look up your coverage information, including services and amounts covered, deductible, co-insurance, and annual benefit maximum, by signing in to MyBlue at **bluecrossma.org** and reviewing your subscriber certificate. You can also call Member Service at the number on the front of your ID card.

Q: My plan has a calendar-year maximum. Is that per person, or do all my family's dental services apply toward one calendar-year maximum? How do I check to see if my maximum has been reached?

A: Your calendar-year maximum applies individually for each person enrolled. To find out how much has been applied toward your plan maximum, call Member Service at the number on the front of your ID card.

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Q: If my cleanings are covered at 100 percent, does that count toward my calendar-year maximum?

A: Generally, all services paid by Dental Blue are applied toward your plan-year or calendar-year maximum. However, if you're enrolled in our Enhanced Dental Benefits program, deductibles and co-insurance don't apply to condition-specific services that are provided in addition to dental benefits already covered by your plan, and condition-specific services are excluded from the calendar-year maximum.

Q: My previous plan had orthodontic coverage, and my child is in the middle of a 24-month treatment plan. Will some orthodontic services still be covered under my new Dental Blue plan?

A: Any remaining orthodontic treatment received after your new plan's effective date will be covered based on your plan's orthodontic benefits and up to the applicable lifetime maximum.

Not all plans include orthodontic coverage. Please review your Dental Blue plan specifics for more details.

Q: How do I enroll in the Enhanced Dental Benefits program?

A: Call Member Service at the number on the front of your ID card to request an enrollment form and to find out more information. You may also be automatically enrolled in the Enhanced Dental Benefits program if you have medical coverage through Blue Cross Blue Shield of Massachusetts and have been identified to have a qualifying medical condition.

Q: My children are covered by both my dental plan and my spouse's dental plan. Am I able to coordinate benefits so I can reduce my out-of-pocket expenses?

A: Yes, specific criteria determine which plan should be billed as the primary coverage when a family has duplicate coverage. If either coverage is a medical plan, that plan would be primary. When the family has both Dental Blue and coverage through another dental insurer, the primary coverage is determined based on the parents' birthdates. Review your benefit information by signing in to MyBlue at **bluecrossma.org**, or check your subscriber certificate for more details.

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DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

At Blue Cross Blue Shield of Massachusetts, we know that oral health is a critical part of overall health. That's why we offer a dental benefit that will allow you to roll over a portion of your unused dental benefits from year to year.

HOW MAXIMUM ROLLOVER WORKS

Beginning 60 days after the last day of your benefit period, your rollover amount will be added to your maximum benefit amount, increasing it for you to use that year and beyond (see below for amounts and maximums).

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

And, your rollover amount keeps growing and is available for you to use as long as your employer offers this rollover benefit.* The last column will show you the total amount of additional benefit dollars you can earn. It's one more way we're working to improve health care for all our members.

You can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures. This benefit applies to you automatically if:

- You receive at least one service during the benefit period
- You remain a member of the plan throughout the benefit period
- You don't exceed the claim payment threshold in the benefit period

If your dental plan's annual maximum benefit amount is:	And if your total claims don't exceed this amount for the benefit period:*	We'll roll over this amount for you to use next year and beyond:*	However, rollover totals will be capped at this amount:*
$500–$749	$200	$150	$500
$750–$999	$300	$200	$500
$1,000–$1,249	$500	$350	$1,000
$1,250–$1,499	$600	$450	$1,250
$1,500–$1,999	$700	$500	$1,250
$2,000–$2,499	$800	$600	$1,500
$2,500–$2,999	$900	$700	$1,500
$3,000 or more	$1,000	$750	$1,500

*This is not a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.

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MASSACHUSETTS

DENTAL BLUE®
ENHANCED DENTAL BENEFITS

Additional Support for Members with Qualifying Conditions

The connection is clear: good oral health leads to better overall health. That's why your Dental Blue plan includes Enhanced Dental Benefits, a total health solution for members with qualifying medical conditions that may require increased oral care. We offer additional, specific support, including full coverage for preventive and periodontal services that have been connected to improved overall health.

Condition	One cleaning or periodontal maintenance, 4 per calendar year[1]	Periodontal scaling, once per quadrant every 24 months[1]	Oral cancer screening, twice per calendar year	Fluoride treatment, 4 per calendar year
DIABETES	✓	✓		
CORONARY ARTERY DISEASE	✓	✓		
STROKE	✓	✓		
PREGNANCY[2]	✓	✓		
ORAL CANCER	✓		✓	✓
SJÖGREN'S SYNDROME	✓		✓	✓
INTELLECTUAL AND/ OR DEVELOPMENTAL DISABILITIES[2,3]	✓		✓	✓
MENTAL HEALTH CONDITIONS[2,3]	✓		✓	✓

1. Periodontal maintenance and scaling are available on plans that offer periodontal benefits. There must be at least three months between a periodontal maintenance cleaning and any other cleanings covered under your dental plan, including these Enhanced Dental Benefits.
2. Self-enrollment is required for this condition. You can download the Enhanced Dental Benefits Enrollment Form at bluecrossma.org/myblue/fast-forms
3. Intellectual and/or Developmental Disabilities and Mental Health Conditions are being added to benefits on renewal starting October 1, 2023.

Note: Certain dental plans cover preventive dental services and Enhanced Dental Benefits at different frequency intervals. Check your plan benefits to confirm your coverage before scheduling dental services.

(Continued)

USING THESE BENEFITS

There's No Additional Cost to Receive These Extra Services[4]

These services aren't subject to a deductible, co-insurance, or annual maximum when provided by a dentist in our network. If you have a PPO plan and choose to receive services from a dentist not in our network, you may have to pay co-insurance.

Accessing Enhanced Dental Benefits

You may be automatically enrolled for these extra services if you have medical coverage through Blue Cross and have been identified to have a qualifying medical condition. However, there are some instances where you'll need to self-enroll using the Enhanced Dental Benefits Enrollment Form.

- You don't have Blue Cross medical coverage
- For the following conditions, even if you have Blue Cross medical coverage:
  - Intellectual and/or developmental disability
  - Mental health condition
  - Pregnancy

4. Qualifying members only.

Questions?

If you have any questions, call Member Service at the number on the front of your ID card.

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ENHANCED DENTAL BENEFITS ENROLLMENT FORM

This is a self-enrollment form to receive Enhanced Dental Benefits from Blue Cross Blue Shield of Massachusetts. Enhanced Dental Benefits provide coverage for additional preventive services for members diagnosed with one or more of the qualifying medical conditions listed below. Please complete this form with your doctor and mail it back to the address provided below to receive these benefits.

(Your dental coverage policy must include Enhanced Dental Benefits in order to be eligible for coverage.)

Please check qualifying medical conditions:

❑ Diabetes ❑ Coronary artery disease ❑ Stroke ❑ Pregnancy (expected date of birth ___/___/____)

❑ Oral cancer ❑ Sjögren's syndrome ❑ Intellectual and/or developmental disabilities* ❑ Mental health conditions*

Subscriber/Member Information

Subscriber Name	Member Name		Date of Birth ___/___/____
Member Address	City	State	ZIP Code
Member Telephone # (Home)	Member Telephone # (Other)		
Blue Cross Blue Shield of Massachusetts Dental ID #			

To Be Completed By Your Doctor

I hereby confirm that my patient has been diagnosed with the conditions listed above. Doctor's Signature		Date ___/___/____
Doctor's Name (please print, circle MD or DO) MD/DO	License #	State
Doctor's Address	Doctor's Telephone #	

Complete this form, keep a copy for your records, and return the original to:

Enhanced Dental Benefits Program
Blue Cross Blue Shield of Massachusetts
Dental Operations
P.O. Box 986040
Boston, MA 02298

*Intellectual and/or developmental disabilities and mental health conditions are being added to benefits on renewal, starting October 1, 2023.

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.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
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**).
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**).

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MASSACHUSETTS

DENTAL BLUE® FREEDOM

With the ability to see any dentist in our Dental Blue® and Dental Blue® PPO networks, as well as out-of-network dentists, Dental Blue Freedom gives you the most choices for dental care. You'll save the most when you get care from an in-network dentist.

PLAN HIGHLIGHTS

Freedom of Choice
With the largest selection of network dentists, plus the ability to see out-of-network dentists, you'll have the most choices for dental care.

No "Balance Billing"
When using our Dental Blue and Dental Blue PPO networks, you won't be billed for the difference between what the dentist charges and the allowed amount.

The Best Rates for In-Network Service
The dentist's charge for services will be lowest when you use the Dental Blue PPO network, while the charge for services from dentists in the Dental Blue network will be slightly higher.

No-Cost Preventive Care
You won't have to pay any out-of-pocket costs for preventive care, such as regular checkups, when you use in-network dentists.

OUR NETWORKS

Dental Blue
Our traditional network offers you access to more than 93 percent of dentists in Massachusetts, as well as a large number of national dentists. Rates for services are slightly higher than those in our PPO network.

Dental Blue PPO
When you visit dentists in our PPO network, you'll get the lowest rates, and pay the least out-of-pocket costs for dental services.

OUT-OF-NETWORK COVERAGE

You have the flexibility to visit out-of-network dentists, but will pay the highest out-of-pocket costs for services.

HOW TO FIND IN-NETWORK DENTISTS

1. Sign in, or create an account at **bluecrossma.com/myblue**.
2. Go to the **Find a Doctor** tool.
3. Fill in all fields and enter Dental Blue or Dental Blue PPO* for your network.
4. Click **Search**.

*Choosing Dental Blue PPO will give you the most coverage.

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Blue MedicareRx℠ (PDP)

2024 SUMMARY OF BENEFITS

2024 Summary of Benefits

Blue MedicareRx (PDP)

Employer Group Medicare Prescription Drug Plan with Supplemental Coverage: $0 / 20%

Option 32

S2893_2312_GRP_M

BLUE MEDICARERX (PDP)

(a Medicare Prescription Drug Plan (PDP) offered by ANTHEM INSURANCE CO. & BCBSMA & BCBSRI & BCBSVT with a Medicare contract)

SUMMARY OF BENEFITS

January 1, 2024 - December 31, 2024

Thank you for your interest in Blue MedicareRx. Blue MedicareRx includes standard Medicare Part D benefits supplemented with coverage provided by your former employer/union health plan. Blue MedicareRx is referred to throughout this Summary of Benefits as "plan" or "this plan."

This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call us and ask for the "Evidence of Coverage."

FOR MORE INFORMATION

Hours of Operation

You can call us 24 hours a day, 7 days a week.

Blue MedicareRx Phone Numbers and Website

Please call Blue MedicareRx for more information about our plan.

Current members should call toll-free **1-888-543-4917**. (TTY/TDD **711**).

Prospective Members, please contact your benefits administrator.

Visit us at our Document Portal: **rxmedicareplans.memberdoc.com.**

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

This document is available in other formats such as Braille and large print. For additional information, call us at **1-888-543-4917**, 24 hours a day, 7 days a week. TTY/TDD users should call **711**.

WHO CAN JOIN?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B, are a US citizen or are lawfully present in the United States and live in the service area which includes the United States and its territories.

If you are enrolled in a MA coordinated care (HMO or PPO) plan or a MA private fee-for-service (MA PFFS) plan that includes Medicare prescription drugs, you may not enroll in a prescription drug plan (PDP) unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private fee-for-service (PFFS) plan that does not provide Medicare prescription drug coverage or a MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP. Please contact your local benefits administrator for more information.

WHICH DRUGS ARE COVERED?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our Document Portal at: **rxmedicareplans.memberdoc.com**. Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COSTS?

Our plan groups each medication into one of 2 “tiers”. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug’s tier, your out-of-pocket prescription costs to date and what stage of the benefit you have reached. Later in this document we discuss the benefit stages in your Medicare prescription drug coverage that occur: Deductible, Initial Coverage, Coverage Gap, and Catastrophic Coverage. For more information about formulary tiers and stages of the benefit, please see the plan’s formulary and the Evidence of Coverage on our Document Portal at: **rxmedicareplans.memberdoc.com**,or contact Customer Care at the number listed above.

WHICH PHARMACIES CAN I USE?

We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan’s pharmacy directory at our Document Portal at: **rxmedicareplans.memberdoc.com**. Or, call us and we will send you a copy of the pharmacy directory.

ADDITIONAL BENEFIT INFORMATION FOR BLUE MEDICARERX

Important message about what you pay for vaccines

Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.

Important message about what you pay for insulin

You won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on.

SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

PRESCRIPTION DRUG BENEFITS

The benefits described below are offered by Blue MedicareRx, a standard Medicare Part D plan supplemented with benefits provided by your former employer.

Initial Coverage		You pay the following until your total yearly drug costs reach $5,030[1]:	
Deductible		$50	
Standard Retail Cost-Sharing		**One-month supply**	**Three-month supply[2]**
Tier 1	Generic	$0	$0
Tier 2	Brand	20%	20%
		Specialty drugs are limited to a one-month supply per fill.[3]	
Mail Order Cost-Sharing		**One-month supply**	**Three-month supply**
Tier 1	Generic	$2	$2
Tier 2	Brand	$15	$15
		Specialty drugs are limited to a one-month supply per fill.	

Coverage Gap	After your total yearly drug costs reach $5,030, your former employer provides supplemental coverage that will keep your copayments and/or coinsurance as outlined above. Your copayments and/or coinsurance will not change until you qualify for Catastrophic Coverage.

Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $8,000, you pay:
Generic (including brand drugs treated as generic)	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
All other Drugs	

1. All covered drugs are on the Blue MedicareRx group formulary/drug list.
2. Available at retail pharmacies that have agreed to allow members to fill 90-day supplies of their prescriptions.
3. Tier 1 Specialty Generic drugs are covered at a flat $0 copayment and Tier 2 Specialty Brand drugs are covered at a flat $25 copayment.

GENERAL INFORMATION

In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.

Certain prescription drugs will have maximum quantity limits.

Your provider must get prior authorization from Blue MedicareRx for certain prescription drugs.

Covered Part D drugs are available at out-of-network pharmacies in special circumstances as long as the pharmacy is located within the United States and its territories. For examples of what would qualify as special circumstances, refer to the Evidence of Coverage (EOC). Your copayment and/or coinsurance at out-of-network pharmacies is the same as at network pharmacies and depends on whether you purchase a Generic, Preferred Brand, Specialty or Non-Preferred drug.

Medicare considers drugs which cost more than $950 for a one month supply to be specialty drugs.

MEDICARE COVERAGE GAP DISCOUNT PROGRAM

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached year-to-date “total drug costs” of $5,030 and are not already receiving “Extra Help.”

If you have reached year-to-date “total drug costs” of $5,030, your former employer provides supplemental coverage that will keep your copayments and/or coinsurance in the Coverage Gap the same as what you pay in the Initial Coverage Level. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs and move you through the Coverage Gap. The amount discounted by the manufacturer will count toward your out-of-pocket costs as if you had paid this amount. Your Explanation of Benefits (EOB) will show any discounted amount provided.

Once your out-of-pocket costs reach $8,000, you will move to the Catastrophic phase and the Medicare Coverage Gap Discount Program will no longer be applicable.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Care.

Blue MedicareRx℠ (PDP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue MedicareRx does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue MedicareRx:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - » Qualified sign language interpreters
  - » Written information in other formats (Braille, large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - » Qualified interpreters
  - » Information written in other languages

If you need these services, call the number on the back of your Member ID Card. TTY/TDD users should call 711.

If you believe that Blue MedicareRx 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:

Blue MedicareRx (PDP)

Grievance Department Coordinator
P.O. Box 30016
Pittsburgh, PA 15222-0330
Phone: 1-866-884-9478
Fax: 1-866-217-3353

You can file a grievance in person, by mail, or fax.
If you need help filing a grievance, Blue MedicareRx Grievance Department 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, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, TTY: 1-800-537-7697

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

You can file a complaint if you feel that you received inaccurate, misleading, or inappropriate information. Please call Customer Care at the number listed on the back page of this booklet (TTY users call: 711). If your complaint involves a broker or agent, be sure to include the name of the broker/agent when filing your complaint.

NOTES

FOR QUESTIONS, OR TO ENROLL:

This information is not a complete description of benefits. Please refer to the contact list below for more information.

Please call Blue MedicareRx for more information about our plan.
Current members should call toll-free 1-888-543-4917. (TTY/TDD 711)
Prospective Members, please contact your benefits administrator.
Visit us at rxmedicareplans.memberdoc.com

Customer Care Hours:

24 hours a day, 7 days a week

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit medicare.gov on the web.

If you have special needs, this document may be available in other formats.

MASSACHUSETTS

SB-8582-2OPT32-24

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MASSACHUSETTS

NURSES RIGHT NOW

When you call our 24/7 Nurse Line, you can speak to a registered nurse, when you need to, day or night. Because guidance and advice should be available around the clock.

YES, YOUR PLAN COVERS IT!

GET CONNECTED DIRECTLY TO A NURSE

365 DAYS A YEAR, INCLUDING HOLIDAYS

THERE'S NO ADDITIONAL COST

KNOW WHEN TO CALL

Nurses can give you advice on:

- Treating a fever, cut, headache, or diarrhea
- Managing a new diagnosis
- Recognizing signs of a concussion after a head injury
- Taking over-the-counter medications or prescriptions
- Upcoming medical tests or appointments
- Deciding if you need immediate care
- Caring for a sick child or family member

In the case of a life-threatening emergency, call 911 or go to the nearest emergency room.

Call Our 24/7 Nurse Line

Nurses are ready around the clock to answer your questions. Call **1-888-247-BLUE (2583)**.

*We partner with Carenet Health®, an independent health care engagement company, to administer this service. Before you can email a nurse, you'll need to create a Carenet Health account using your nine-digit Blue Cross member ID number (without the letter prefix).

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.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
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**).
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**).

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MASSACHUSETTS

MIND AND BODY REIMBURSEMENT

Great holistic health shouldn't be a stretch. Get reimbursed for qualified services and apps.

Save up to

$300

per family per calendar year.

Qualified for Mind and Body Reimbursement:*

- Massage therapy
- Hypnosis therapy
- Meditation therapy
- Tai chi
- Qi (chi) gong
- Breathing and meditation apps

Not Qualified for Mind and Body Reimbursement:

- Visits to nutrition providers or other services included in the Fitness or Weight-Loss Reimbursement programs
- Apps not focused on breathing or meditation, such as those focused on sleep

Find a Qualified Provider and Save

You can get up to 30 percent off standard rates when you use an alternative health practitioner in our network. You'll also have peace of mind knowing that your practitioner is accredited in their field and meets specific requirements for education, training, and facilities. To search for a practitioner, go to **bluecrossma.org**.

Be sure to check with your doctor before receiving alternative medicine services.

GET REIMBURSED IN THREE EASY STEPS

1

Choose
Start by selecting a qualified mind and body service or app.

2

Complete
After you pay for the service or app, fill out the attached form.

3

Mail
Send the completed form to the address listed.

Questions?

To learn more about your alternative health care benefits, sign in to MyBlue at **bluecrossma.com/myblue** or call Member Service at the number on the front of your ID card.

*Practitioners must be licensed, certified, or accredited for a service to qualify for reimbursement.

MIND AND BODY REIMBURSEMENT REQUEST

Please print all information clearly. All reimbursement requests must be submitted by March 31 of the following year.

Complete this form and mail it to: Blue Cross Blue Shield of Massachusetts, Local Claims Department, PO Box 986030, Boston, MA 02298

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial

Address — Number and Street	City	State	ZIP Code

Employer's Name

Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth ___/___/____

Claim is for (choose one and color in the entire box):

- ❑ Subscriber (policyholder)
- ❑ Spouse (of policyholder)
- ❑ Ex-Spouse
- ❑ Dependent (up to age 26)
- ❑ Other (specify):

Name, Address, and Phone Number for Qualified Expense (Service or App)

Total dollars requested: $ _____

Calendar year: _____

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)

I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these services. I enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/____

Important Information:

- Keep copies of proof of payment in case we request them from you.
- Mind and Body reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a complete request.
- Reimbursement requests must be submitted by March 31 of the following year.
- Reimbursement may be considered taxable income, so you should consult a tax advisor.

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MASSACHUSETTS

WEIGHT-LOSS REIMBURSEMENT

Your reward for healthy behavior:
Receive up to $150 annually when you participate in a qualified weight-loss program.[1]

Qualified for Weight-Loss Reimbursement

Participation fees for:

- Hospital-based programs and Weight Watchers® in-person
- Weight Watchers online and other non-hospital programs (in-person or online) that combine healthy eating, exercise, and coaching sessions with certified health professionals such as nutritionists, registered dietitians, or exercise physiologists.

Not Qualified for Weight-Loss Reimbursement

- One-time initiation or termination fees
- Food, supplements, books, scales, or exercise equipment
- Individual nutrition counseling sessions, doctor/nurse visits, lab tests, or other services that are covered benefits under your medical plan

GET REIMBURSED IN THREE EASY STEPS

1

Choose
Start by picking a qualified weight-loss program.

2

Complete
Once you pay for the program, fill out the attached form, or sign in to MyBlue to submit online at **member.bluecrossma.com/login**.

3

Mail
Send the completed form to the address listed.

Be sure to check with your doctor before starting any weight-loss program.

1. To verify this reimbursement is offered for your plan, or for more information, sign in to MyBlue at **bluecrossma.com/myblue** or call the Member Service number on your ID card. Most plans offer the reimbursement shown, but refer to your plan information for specific details.

Questions?

Contact Member Service by calling the phone number on your member ID card.

WEIGHT-LOSS REIMBURSEMENT REQUEST

Please Print All Information Clearly: To verify this reimbursement is offered within your plan, or for more information, please sign in to MyBlue at **bluecrossma.com/myblue** or call the Member Service number on your ID card. All weight-loss reimbursement requests must be submitted by March 31 of the following year.

Complete this form and mail it to: Blue Cross Blue Shield of Massachusetts, Local Claims Department , PO Box 986030, Boston, MA 02298

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial

Address - Number and Street	City	State	Zip Code

Employer's Name

Claim Information

Member Last Name	First Name	Middle Initial	Gender (color in the entire box) ❑ Male ❑ Female	Date of Birth ___/___/____

Claim is for (choose one and color in the entire box):

❑ Subscriber (policyholder)
❑ Spouse (of policyholder)
❑ Ex-Spouse
❑ Dependent (up to age 26)
❑ Other (specify):

Name, Address, and Phone Number of Qualified Weight-Loss Program

Total dollars requested: $ _____

Monthly program participation fee: $ _____

Calendar Year: ___/___/____

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)
I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified weight-loss program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date: ___/___/____**

Important Information:

- Weight-loss reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a completed request.
- Reimbursement requests must be submitted by March 31 of the following year.
- Keep copies of proof of payment in case we request it from you. Proof of payment includes:
  - Receipts (cash/check/credit/electronic) for participation fees clearly documenting your name, the weight-loss program name, and individual amounts charged with date paid.
  - Your weight-loss program membership or participation agreement clearly documenting your name and date of enrollment/participation.
- Your reimbursement may be considered taxable income, so consult a tax advisor.

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MASSACHUSETTS

FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

$150

Qualified for Reimbursement:

- A full service health club with cardiovascular and strength-training equipment like treadmills, bikes, weight machines, and free weights
- A fitness studio with instructor-led group classes such as yoga, Pilates, Zumba®, kickboxing, indoor cycling/spinning, and other exercise programs
- Online fitness memberships, subscriptions, programs, or classes
- Cardiovascular and strength-training equipment for fitness that is purchased for use in the home, such as stationary bikes, weights, exercise bands, treadmills, fitness machines

Not Qualified for Reimbursement:

- One-time initiation or termination fees
- Fees paid for gymnastics, tennis, pool-only facilities, martial arts schools, instructional dance studios, country clubs or social clubs, sports teams or leagues
- Personal trainer sessions
- Fitness clothing

Get Started

To submit your reimbursement, sign in to MyBlue at **bluecrossma.org**.

Your reimbursement is waiting!

MASSACHUSETTS

FITNESS REIMBURSEMENT REQUEST

Please print all information clearly. To verify that this reimbursement is offered within your plan, or for more information, you can sign in to MyBlue at **bluecrossma.org** or call the Member Service number on your ID card.
All fitness reimbursement requests must be submitted by March 31 of the following year.

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	**Subscriber's Last Name**	**First Name**	**Middle Initial**
Address – Number and Street	**City**	**State**	**ZIP Code**
Employer's Name			

Claim Information

Member's Last Name	**First Name**	**Middle Initial**	**Date of Birth** ___/___/____

Claim is for (choose one and color in the entire box):

- ☐ Subscriber (policyholder)
- ☐ Spouse (of policyholder)
- ☐ Ex-Spouse
- ☐ Dependent (up to age 26)
- ☐ Other (specify): _____

Name, Address, and Phone Number of Qualified Fitness Expense

Total Dollars requested for Qualified Fitness Expense: $ _____

Calendar year that fees were paid: _____

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)
I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these services. I enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/____

Complete this form and mail it to:
Blue Cross Blue Shield of Massachusetts,
Local Claims Department,
PO Box 986030, Boston, MA 02298

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BlueCross BlueShield

Worldwide Coverage

For Foreign and Domestic Travelers

Get quality health care no matter where you are in the world.

Whether you're traveling within the United States or abroad, BlueCard®' and Blue Cross Blue Shield Global® Core make sure you have access to top doctors and hospitals and concierge-level service.

Call **1-800-810-BLUE (2583)** for a list of participating doctors and hospitals, or to obtain an international claim form.

Take this reference card with you when you travel.

When you need care, you'll be prepared.

TEAR HERE

Urgent Care

1. Call **1-800-810-BLUE (2583)**, or visit **bcbs.com** to find nearby doctors and hospitals anywhere in the world that participate in the Blue Cross Blue Shield network.
2. Show your member ID card when you get care.
3. If you're admitted, or if you have questions about your coverage, call Member Service at the number on the front of your ID card.

Your Passport to Good Health

Always carry your Blue Cross Blue Shield of Massachusetts ID card.

FOLD HERE

Emergency Care

For emergency services, call the local emergency number or go to the nearest hospital immediately.

Getting Care in the United States

More than 85 percent of all doctors and hospitals in the United States participate in the BlueCard program. If you need care outside your plan's service area, call **1-800-810-BLUE (2583)**, or visit **bcbs.com** to find a doctor near you. Be sure to show your ID card before you receive service.

When you get service:

- There's no paperwork
- Participating doctors and hospitals submit claims for you
- All you pay is the copayment, co-insurance, or deductible
- If you receive care from a non-participating doctor or hospital, you may need to pay for the services up front and submit a claim for reimbursement

BlueCard PPO Members Only: If you see this symbol, PPO, on your ID card, you're a BlueCard PPO member. To save the most money when getting service, use a participating BlueCard PPO doctor or hospital.

In Case of Emergency

For emergency services, call the local emergency number or go to the nearest hospital immediately.

Getting Care Outside the United States

The Blue Cross Blue Shield Global® Core network gives you access to doctors and hospitals around the world. If you need care, call the Service Center at **1-800-810-BLUE (2583)**, or call collect at **1-804-673-1177**, 24 hours a day, 7 days a week. An assistance coordinator, along with a medical professional, will arrange a doctor's appointment or hospitalization if necessary. You can also visit **bcbsglobalcore.com**.

TEAR HERE

BlueCross BlueShield

An Association of Independent Blue Cross and Blue Shield Plans

FOLD HERE

Primary Care Provider's Name: _____

Doctor's Phone: _____

Doctor's Hospital Affiliation: _____

Your Blue Cross Blue Shield Member ID: _____

Member Service Phone Number (from your ID card): _____

For Inpatient Services:

- Call the Service Center at **1-800-810-BLUE (2583)**, or Member Service at the number on your ID card, for precertification or preauthorization
- In most cases, all you pay is the copayment, co-insurance, or deductible
- The hospital should submit the claim on your behalf

For Outpatient Services:

- Show your ID card
- Pay the doctor or hospital
- Fill out a Blue Cross Blue Shield Global® Core International Claim form for reimbursement (Call **1-800-810-BLUE (2583)** or visit **bcbsglobalcore.com** for the form)
- You're only responsible for copayments, co-insurance, or deductible when seeing in-network doctors and hospitals
- You'll pay more when seeing out-of-network doctors and hospitals

Doctors and Hospitals

In most cases, participating doctors and hospitals will file the claim for you. If they need information about eligibility or your coverage, have them call **1-800-676-BLUE (2583)**.

Your Member Responsibilities

As a Blue Cross Blue Shield of Massachusetts member, you're still responsible for any copayments, co-insurance, deductible, or non-covered services. For out-of-country services, Blue Cross Blue Shield of Massachusetts payments will be based on the provider's charge.

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.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID Card (TTY: **711**).

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**).

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**).

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MASSACHUSETTS

OUR COMMITMENT TO CONFIDENTIALITY (NOTICE OF PRIVACY PRACTICES) AND WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

This notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Commitment: We respect your right to privacy. We will not disclose personally identifiable information about you without your permission, unless the disclosure is necessary to provide our services to you or is otherwise in accordance with the law.

Collection of Information

We collect only the information about you that we need to operate our business. We collect information from other parties, such as your health care providers and employers. Examples of the information we collect are (i) medical and dental information from health care providers when they submit claims for services and (ii) personal information such as name, address, and date of birth, which is most often supplied by you or your employer when you enroll in a plan.

USE AND DISCLOSURE OF INFORMATION

We are required by law to protect the confidentiality of information about you and to notify you in case of a breach affecting your information. We may use and disclose information about you without your written authorization for the following purposes, to the extent otherwise permitted or required by law:

You or Your Representatives—to you or your "personal representative" upon request or to help you (or your personal representative) understand treatment options, benefits, or the rights available to you. Your "personal representative" is a person who has legal authority to make health-related decisions on your behalf, such as a person with a health-care power of attorney. Your request must be in writing. Please complete the Documentation of Legal Representative Status for Members form available on our website. You also may designate a family member or friend to receive information and interact with us on your behalf. Your designation and any subsequent revocation must be in writing. Please complete the Member's Designation of an Authorized Representative form available on our website. You may also call Member Service for a copy of these forms.

- **Treatment**—to help health care providers manage or coordinate your health care and related services. For example, we may use and disclose information about you to inform providers of medications you take or to remind you of appointments.
- **Payment**—to obtain payment for your coverage, pay claims for your health benefits, or help another health plan or health care provider in its payment activities. For example, we may use or disclose information about you to make coverage determinations, administer claims, or coordinate benefits with other coverage you may have.
- **Health Care Operations**—to perform other activities necessary for the operation of our business, including customer service, disease management, and determining how to improve the quality of care. For example, we may use or disclose information about you to respond to your call to customer service, arrange for medical review of your claims, or conduct quality assessment and improvement activities.

- **Legal Compliance**—to comply with applicable law. For example, we may be required to use or disclose information about you to respond to regulatory authorities responsible for oversight of government benefit programs or our business operations; to parties or courts in the course of judicial or administrative proceedings; or pursuant to workers' compensation laws.
- **Government Agencies**—under limited circumstances established by law, to public health authorities, coroners or medical examiners, law enforcement, or other government officials
- **Research**—for health-related research studies that meet legal standards for protection of the individuals involved in the studies and their personal information. We may also create a database of our members' information that does not include individual identifiers and use the database for research or other purposes, provided that the information cannot be traced back to specific members.
- **To Your Employer** (or other plan sponsor), if applicable, for administration of its health plan. This applies only if you receive coverage through an employer-sponsored plan (or plan sponsored by your union or other entity). For example, we may disclose information about you to your employer (or other plan sponsor) to confirm enrollment in the plan or (if the employer or other plan sponsor is self-insured) for claim review and audits. We will disclose your information only to designated individuals. That, along with legal prohibitions on use of your personal information for discriminatory purposes, helps protect your information from unauthorized use.

To carry out these purposes, we share information with entities that perform functions for us subject to contracts that limit use and disclosure for intended purposes. We use physical, electronic, and procedural safeguards to protect your privacy. Even when allowed, we limit uses and disclosures of your information to the minimum amount reasonably necessary for the intended task.

The Health Insurance Portability and Accountability Act (HIPAA) generally does not override other laws that give people greater privacy protections. As a result, we must comply with any state or federal privacy laws that require us to provide you with more privacy protections. For example, federal law provides special protections for substance use disorder information; Massachusetts state law restricts the disclosure of HIV and AIDS related information. In addition, we will not use (and are prohibited from using) your genetic information for underwriting purposes.

OTHER DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION

Except as provided in this notice, we will not use or disclose information about you without your written authorization. For example, we must have your written authorization to use or disclose your information for marketing purposes or (in most cases) to use or disclose psychotherapy notes. Although we would need written authorization to sell information about you, we do not sell members' information.

You may revoke your authorization at any time. Your authorization must be in writing. Your revocation will not affect any action that we have already taken in reliance on your authorization. If you would like us to disclose information about you to a third party, please complete the Permission for One-Time Disclosure of Information form available on our website or call Member Service for a copy of the form.

YOUR PRIVACY RIGHTS

You have the following rights with respect to information about you. You may exercise any of these rights by calling the Member Service number listed on your member ID card or contacting us at the address listed at the end of this notice. The forms listed below are also available on our website.

- **You have the right to receive information about privacy protections.** Your member-education materials include a notice of your rights, and you may request a paper copy of this notice at any time.
- **You have the right to inspect and get copies of information that we use to make decisions about you.** This is your designated record set. Your request must be in writing. We may charge a reasonable fee for copying and mailing you this information. Please complete the Request for Access to Copies of Protected Health Information in Designated Record Set form to request copies of your information.
- **You have the right to receive an accounting of certain disclosures that we make of information about you.** Your request must be in writing. Please complete the Members Request for an Accounting of Disclosures form. Our response will exclude any disclosures made in support of treatment, payment, and health care operations or that you authorized (among others). An example of a disclosure that would be reported to you is our disclosure of your information in response to a court order.
- **You have the right to ask us to correct or amend information you believe to be incorrect.** Your request to correct or amend information must be in writing. Please complete the Members Request to Amend Protected Health Information form. If we deny your request, you may ask us to make your request part of your records.

- **You have the right to ask that we restrict or refuse the disclosure of information about you and that we direct communications to you by alternative means or to alternative locations.** While we may not always be able to agree to your request, we will make reasonable efforts to accommodate requests. Unless you've notified us to request a different mailing address, Summary of Health Plan Payments statements for the subscriber, and all members listed on the subscriber's plan, are generally delivered to the subscriber's address. Under certain circumstances, you can request to not receive statements for a particular service, or to have statements delivered through an alternate method or to an alternate address, when required by state law. If you have concerns about protecting the privacy of your medical information in your statements, you can have these statements delivered to an address other than the plan subscriber's address, or have them delivered only via electronic means. For help understanding your delivery options, please call Member Service at the number listed on your member ID card. Your request and any subsequent revocation must be in writing.

If you believe your privacy rights have been violated, you have the right to complain to us using the grievance process outlined in your benefit materials, or to the Secretary of the U.S. Department of Health and Human Services, without fear of retaliation.

ABOUT THIS NOTICE

The original effective date of this notice was April 14, 2003. The effective date of the most recent revision is indicated in the footer of this notice. We are required by law to provide you with this notice of our legal duties and privacy practices and to abide by the notice for as long as it is in effect. We reserve the right to change this notice. Any changes will apply to all information that we maintain, regardless of when it was created or received. If we make a material change to this notice, we will post the revised notice on our website and notify you of the change and how to obtain the revised notice in our next regular mailing to you. If you have any questions, please call the Member Service number listed on your member ID card, or write us at:

Blue Cross Blue Shield of Massachusetts
Privacy Officer
101 Huntington Ave.
Suite 1300
Boston, MA 02199-7611

WHCRA NOTICE

Did you know that your medical plan provides benefits for many mastectomy-related services? This is the case even if you were not covered by Blue Cross Blue Shield of Massachusetts at the time of the mastectomy. It's required by the Women's Health and Cancer Rights Act of 1998. If you are covered for a mastectomy and elect breast reconstruction in connection with a mastectomy, then benefits are also provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage will be provided as determined in consultation with you and your attending doctor. The costs that you pay for these services are the same as those you pay for other services in the same category. To learn more, please call the Member Service number on your member ID card.

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.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).

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**).

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Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

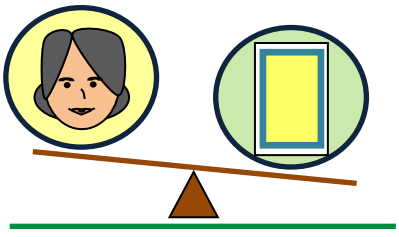
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



Jane pays 20% | Her plan pays 80%

(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

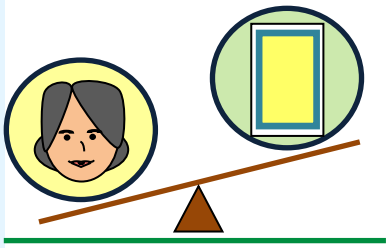
Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

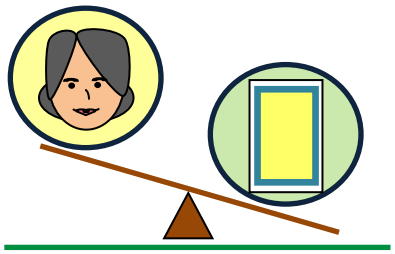
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

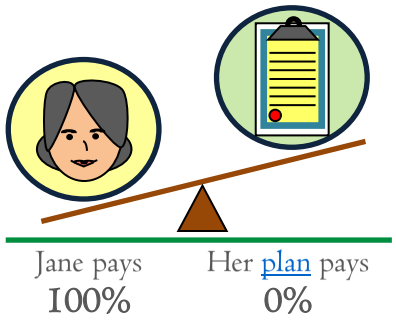
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

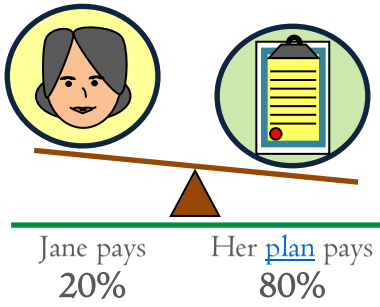
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

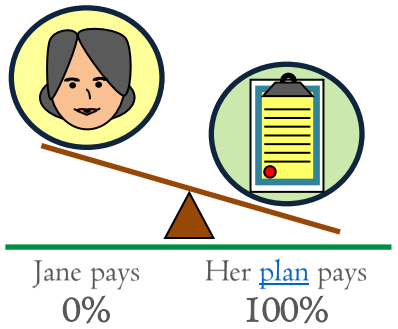
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

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A Guide to Your Summary of Health Plan Payments[1]

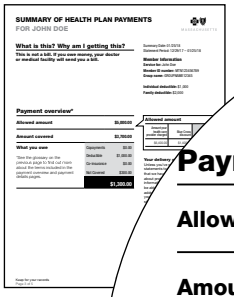
The Summary of Health Plan Payments shows you how we process claims for medical services you've received. This statement is not a bill.

How the Payment Process Works

When you visit a health care provider, you pay a copayment.[2]

The provider submits a bill for services to Blue Cross. This is called a claim.

You'll get a Summary of Health Plan Payments if there's a balance remaining after we process the claim and pay our share of the costs. Your provider will send you a bill if you owe any money.



This is not a bill.

Payment overview*

Allowed amount	**$5,000.00**
Amount covered	**$3,700.00**
Amount you owe	
Copayments	$0.00
Deductible	$1,000.00
Co-insurance	$0.00
Not Covered	$300.00
	$1,300.00

Amount covered by Blue Cross

*See the glossary on the previous page to find out more about the terms included in the payment overview and payment details pages.

Amount you owe (if any)

Copayments

Your copayments (also known as a copay) are the fixed dollar amount you pay each time you see a provider[2] or fill a prescription. Look for your copay amount on your member ID card.

Deductible

If your plan has a deductible, this is the amount of money you pay out-of-pocket for health care services, such as blood tests and x-rays, before Blue Cross starts to pay for them.

Co-insurance

If your plan has co-insurance, you're responsible for paying a predetermined percentage of your medical expenses once your deductible has been met.

Tip: See the glossary on page 2 of your statement for the meaning of any unfamiliar terms.

The provider sends you a bill. (if you owe money)

You pay your provider.

Financial accounts can help cover costs.

If your plan has a Health Reimbursement Arrangement, Health Savings Account, or Flexible Spending Account, you can use it to pay medical expenses, such as your deductible and copayments. You can also use these accounts to pay for eyeglasses and dental services.

1. Medex members receive statements called Explanation of Benefits.
2. Except for certain plans, preventive services are fully covered. Some plans may require co-insurance.

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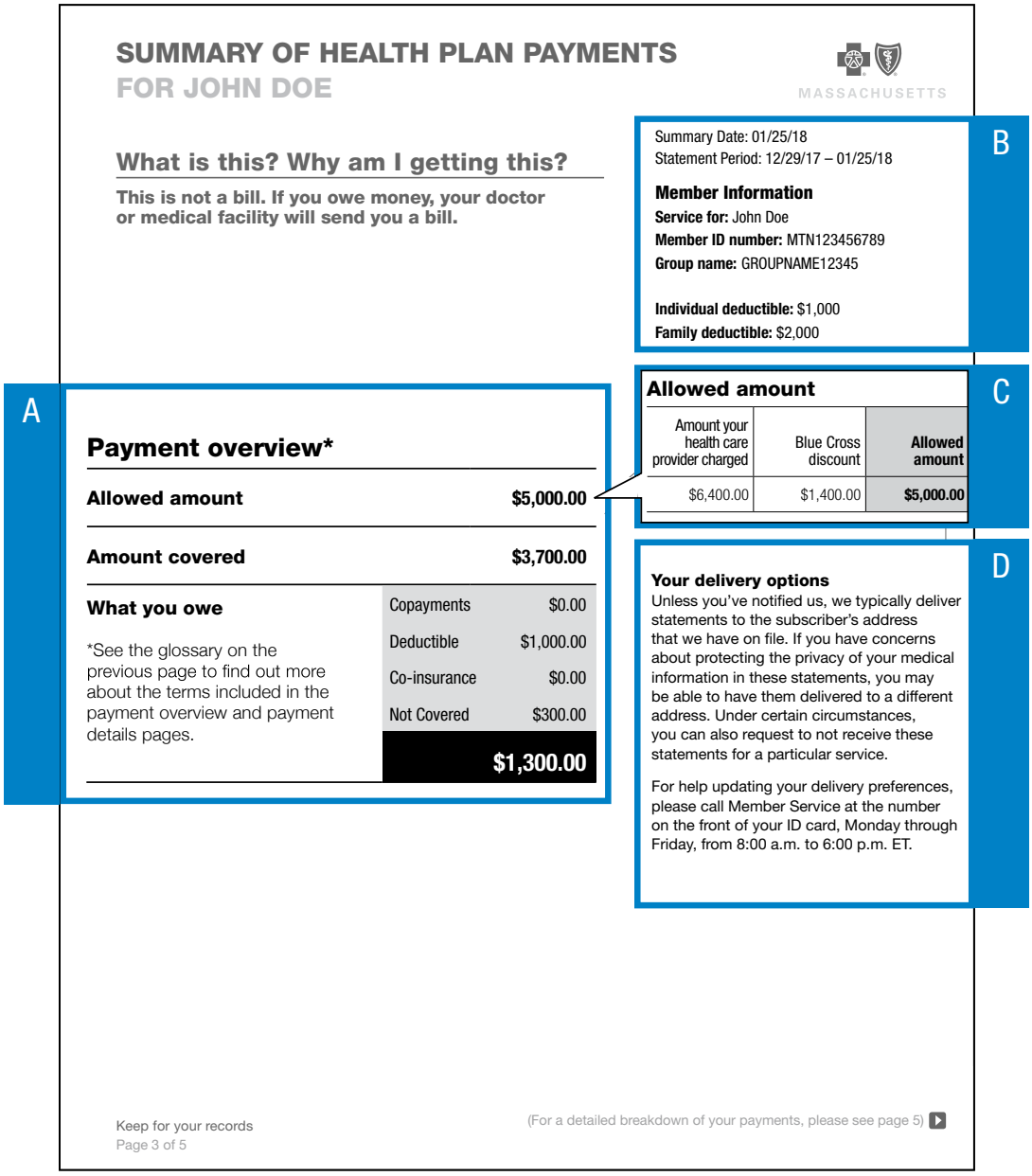
Your Summary of Health Plan Payments

Payment Overview Page



A The payment overview shows the amount charged to Blue Cross, the amount we covered, and what you owe (if anything).

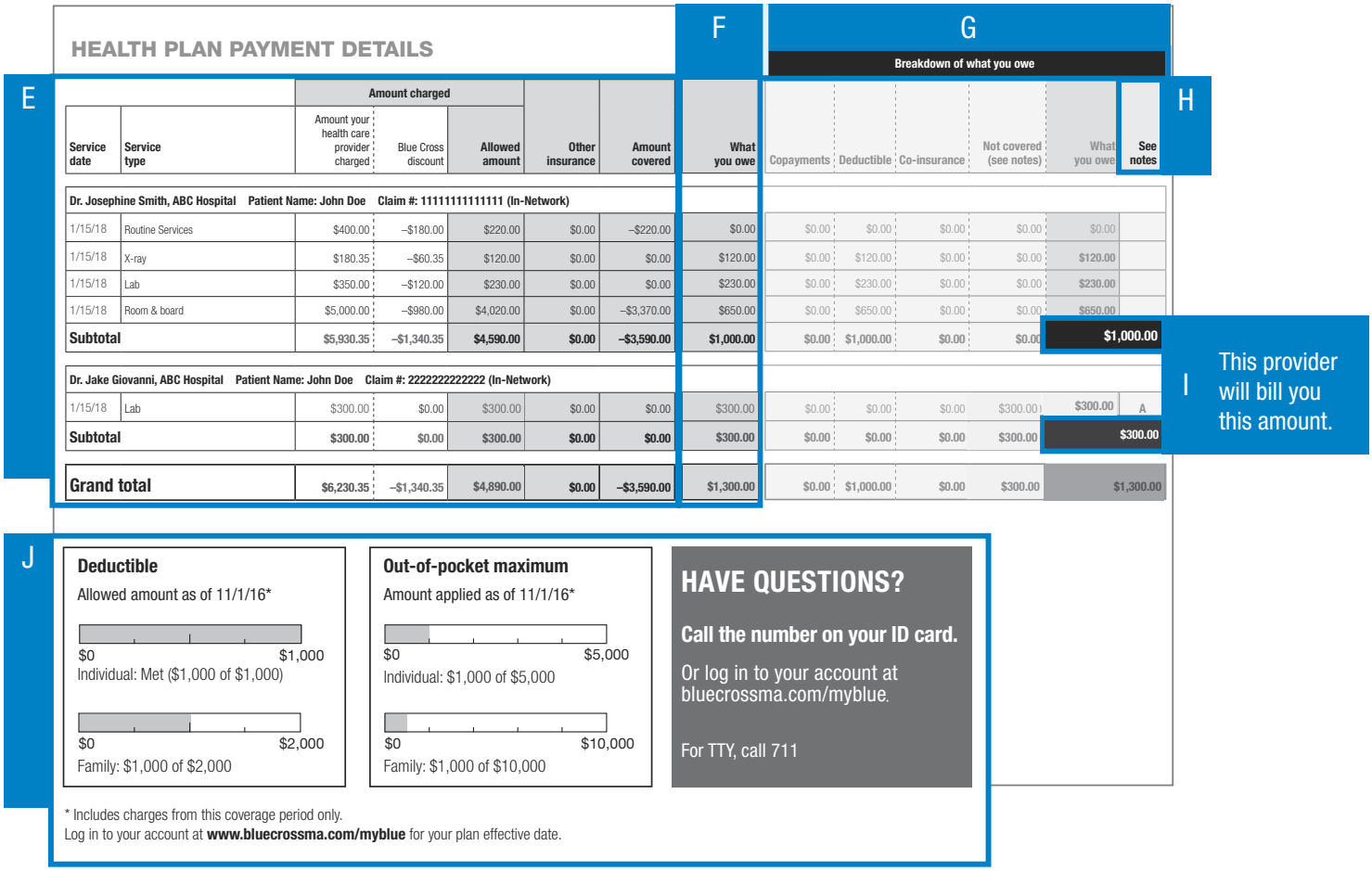
B Up here, you'll find your account information, including your plan's deductible. A deductible is the amount you pay for medical services before your insurance begins to pay.

C This section shows how the allowed amount was calculated.

D Your delivery options describes how these statements are delivered and how you can update your preferences.

Your Summary of Health Plan Payments

Payment Details Page



HEALTH PLAN PAYMENT DETAILS

F

G

Breakdown of what you owe

E

H

Service date	Service type	Amount charged: Amount your health care provider charged	Amount charged: Blue Cross discount	Amount charged: Allowed amount	Other insurance	Amount covered	What you owe	Copayments	Deductible	Co-insurance	Not covered (see notes)	What you owe	See notes
Dr. Josephine Smith, ABC Hospital Patient Name: John Doe Claim #: 11111111111111 (In-Network)													
1/15/18	Routine Services	$400.00	–$180.00	$220.00	$0.00	–$220.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
1/15/18	X-ray	$180.35	–$60.35	$120.00	$0.00	$0.00	$120.00	$0.00	$120.00	$0.00	$0.00	$120.00	
1/15/18	Lab	$350.00	–$120.00	$230.00	$0.00	$0.00	$230.00	$0.00	$230.00	$0.00	$0.00	$230.00	
1/15/18	Room & board	$5,000.00	–$980.00	$4,020.00	$0.00	–$3,370.00	$650.00	$0.00	$650.00	$0.00	$0.00	$650.00	
Subtotal		$5,930.35	–$1,340.35	$4,590.00	$0.00	–$3,590.00	$1,000.00	$0.00	$1,000.00	$0.00	$0.00	$1,000.00	
Dr. Jake Giovanni, ABC Hospital Patient Name: John Doe Claim #: 2222222222222 (In-Network)													
1/15/18	Lab	$300.00	$0.00	$300.00	$0.00	$0.00	$300.00	$0.00	$0.00	$0.00	$300.00	$300.00	A
Subtotal		$300.00	$0.00	$300.00	$0.00	$0.00	$300.00	$0.00	$0.00	$0.00	$300.00	$300.00	
Grand total		$6,230.35	–$1,340.35	$4,890.00	$0.00	–$3,590.00	$1,300.00	$0.00	$1,000.00	$0.00	$300.00	$1,300.00	

I This provider will bill you this amount.

J

Deductible

Allowed amount as of 11/1/16*

$0 $1,000

Individual: Met ($1,000 of $1,000)

$0 $2,000

Family: $1,000 of $2,000

Out-of-pocket maximum

Amount applied as of 11/1/16*

$0 $5,000

Individual: $1,000 of $5,000

$0 $10,000

Family: $1,000 of $10,000

HAVE QUESTIONS?

Call the number on your ID card.

Or log in to your account at bluecrossma.com/myblue.

For TTY, call 711

* Includes charges from this coverage period only.
Log in to your account at **www.bluecrossma.com/myblue** for your plan effective date.

E Your recent claims, including dates of service, names of providers, the amounts charged, and payment details.

F The amount you owe for each service.

G How we determined what you owe, including copayments, deductible, and co-insurance.

H Additional information on how we processed your claims.

I The final amount you'll owe your provider for services after we cover our share of the cost. If you have additional insurance, this doesn't apply to you.

J A detailed breakdown of your deductible and out-of-pocket maximum, including the amounts you've previously applied towards these.

View your plan information and recent claims at **bluecrossma.com/myblue.**

Questions?

Call us at the number on your ID card or log in to your account at **bluecrossma.com/myblue**, click **Contact Us**, then enter your question using the **secure inquiry form** in the Member Service section.

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55-1305 (04/18)

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Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

Before You Begin

Please carefully read the instructions below.

For members of HMO Blue,® Network Blue,® Blue Choice,® HMO Blue New England,℠ or Blue Choice New England℠: You're required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting **bluecrossma.com** and selecting **Find a Doctor**.

For Access Blue℠ Members: Although you're not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

Important: Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Please be sure to check either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Sections 2 and 3.

Please print two copies of your completed application. Keep one for your records and give the other to your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you're seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298
Fax: 1-617-246-7531

163537 36-3630 (11/17)

Instructions

Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

Type of Transaction—Check the box(es) that apply.

Subscriber Cancellation Codes. If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling
041	• Changing to other health plan • Voluntary termination • COBRA cancellation (under 18 months or nonpayment)
042	• Over 65, changing to Group Medex® plan. (Requires Medicare A and B) • Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) • Over 65, changing to Medicare supplement other than Medex plans.
043	• Medicare (age =< 65)

Code #	Reason for Canceling
061	• Left employment • COBRA ending
063	• Transfer
064	• Cancellation as of original effective date
070	• Deceased
071	• Moved out of state (out of HMO service area)
076	• Military service

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions, contact your account service representative.
- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation. If you have questions, contact your account service representative.

Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID#—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (***not*** the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at **1-800-821-1388**. A representative will be happy to help you select a doctor. PCP ID number can be found at **bluecrossma.com**, select **Find a Doctor**.

Other Insurance—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*)) in the correct box. If you have other insurance, please write the name of the other insurance company and your member identification number.

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Member 2

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an **Individual** membership.)

Other Insurance—Does your spouse have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a **Family** membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: dependents cannot be covered under an **Individual** membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

For each option:

Start Date: Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated, and submitted the completed application for these accounts on or before that date.

End Date: Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions, please see your employer.

Note: If you are transferring from one medical/dental plan to another plan, please complete Section 5 of the Enrollment and Change Form to let us know that you will be continuing your personal savings account..

Section 6 Signatures (Employer & Employee)

Employee: Please sign and date the application and return it to your employer. Employer: Please sign and date the application and return to Blue Cross Blue Shieldof Massachusetts.

Please mail to:

P.O. Box 986001
Boston, MA 02298
or fax to 1-617-246-7531

* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group # Transfering To:

Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group # Transferring To

Type of Transaction
❒ ADD ❒ CANCEL
❒ CHANGE Three digit termination code ☐☐☐
❒ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

❒ Open Enrollment ❒ New Hire ❒ COBRA

Change to Family ❒ Add Spouse ❒ Add Dependent

❒ Loss of Coverage (HIPAA Continuation of Coverage Letter required)

❒ Other: _____

2. Yourself (Member 1)

What products? ❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England ❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue ❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group) ❒ Network Blue ❒ PPO ❒ Saver Blue

Membership Type (Medical) ❒ Individual ❒ Family

Membership Type (Dental) ❒ Individual ❒ Family

First Name	M.I.	Last Name	Sex	Date of Birth

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Home Phone ( )	Cell Phone ( )	Email

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered)

Plan Type: ❒ Medical ❒ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

4. Your Eligible Dependents (Member 3, 4 and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **HSA: Health Savings Account**			
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

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GETTING MORE. NOW THERE'S A PLAN.

Your plan has more benefits than you probably realize. Tap into all of them, all in one place.

The MyBlue App is your key to more features and savings. Plus, up-to-date status for claims, your deductible, account balances, and more. It's like a free upgrade for the plan you already have.

UNLOCK THE POWER OF YOUR PLAN

The MyBlue App gives you an instant snapshot of your plan, including:

- COVERAGE AND BENEFITS
- CLAIMS AND BALANCES
- FITNESS AND WEIGHT-LOSS REIMBURSEMENT
- MEDICATION LOOKUP
- VIDEO DOCTOR VISITS USING WELL CONNECTION

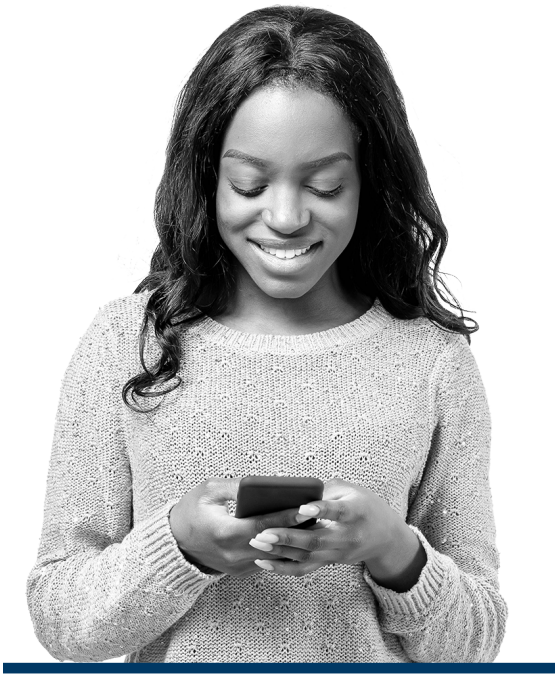
Get the App

Download the app from the App Store®℠ or Google Play™.

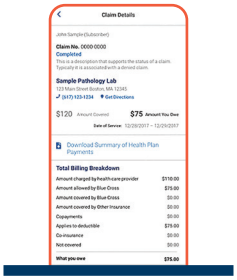
STAY ON TOP OF YOUR COVERAGE

It's never been easier, faster, or more convenient.

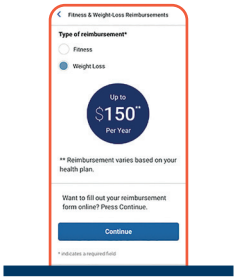
YOUR PLAN IN YOUR HAND



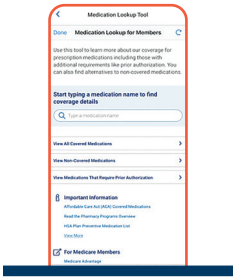
Once you sign in or create a MyBlue App account, you can see all of your benefits, all in one place.
Track your claims, medications, account balances, and more from your device. And, you can easily keep track of reimbursements and savings.



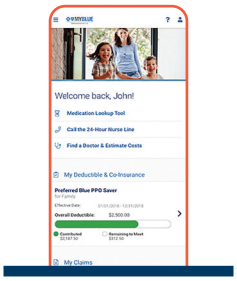
Track claims and benefits
Keep up to date on benefits and coverage.



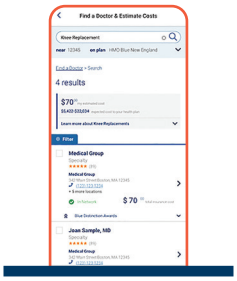
Fitness and weight-loss reimbursement
The online forms are here, along with other savings and offers.



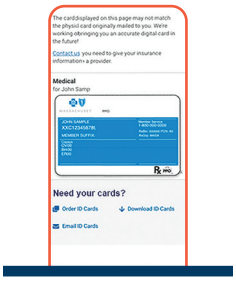
Your medications at a glance
Their names, costs, and prescriptions at your fingertips.



Check deductible balances
End the guesswork and know for sure every time.



Find a Doctor
Or a specialist, dentist, or facility. On your phone and on the fly.



Need your cards
Access your ID cards without opening your wallet.

GET THE MYBLUE APP

You can download the MyBlue App from the App Store®✓ or Google Play™.

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MASSACHUSETTS

CALL TEAM BLUE

Let us know if you have more than one plan by calling us at **1-888-799-1888**.

COORDINATION OF BENEFITS ENSURES YOUR BEST COVERAGE

If you're covered by more than one medical or dental insurance plan, you must inform us which ones you have so we can coordinate your benefits. This will help us work with your other plans, to make sure you get the best coverage when you receive medical or dental services. It will also ensure that your claims are processed correctly.

HOW TO KNOW WHEN COORDINATION OF BENEFITS IS NEEDED

When you have more than one insurance plan, one plan is designated as your primary plan and will pay your claims first. The other plan(s) will pay toward the remaining cost. Federal and state rules will usually determine which plan is primary. You may need coordination of benefits if:

- You and your spouse each have separate insurance plans through your employers
- Your child has one insurance plan through school and another through you or an employer
- Your child has multiple plans as the result of a divorce or custody arrangement
- You or a family member also have Medicare coverage

WHAT TO DO IF YOU HAVE MORE THAN ONE MEDICAL OR DENTAL PLAN

- Call each insurer to let them know. Each insurer can tell you which plan is primary and which is secondary. When calling, be sure you have your member ID cards ready.
- When you visit a doctor, dentist, or hospital, present each insurance card to the office on the day of your visit. This information is needed to determine which company should be billed as a primary insurer, and which should be billed as a secondary insurer.
- If one of your insurance plans is canceled, you'll need to inform the other plan(s).

IF YOU'RE TURNING 65 YEARS OLD AND THINKING ABOUT MEDICARE

Call Medicare directly at **1-800-MEDICARE** (**1-800-633-4227**).

If you sign up for Medicare, call us at **1-888-799-1888** to submit your new plan information. If you don't call us, your claims could be delayed or processed incorrectly.

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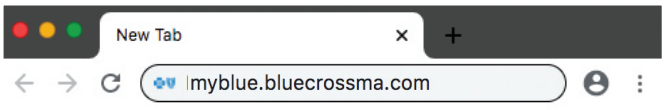
MASSACHUSETTS

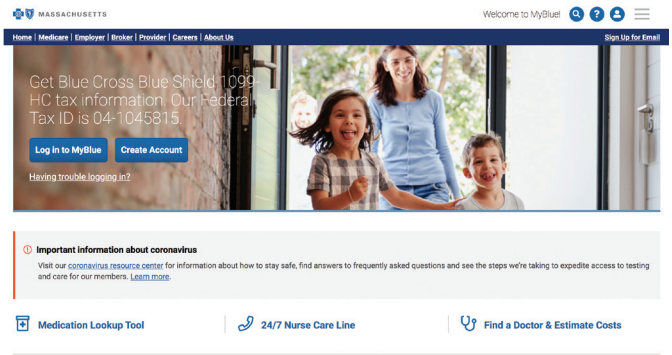
HOW TO FIND YOUR PRIMARY CARE PROVIDER'S ID NUMBER

Instructions for Using Our Find a Doctor & Estimate Costs Tool

If your plan requires you to choose a primary care provider (PCP), you'll need to enter your PCP's ID number on your enrollment form. You can find this number in your plan's provider directory, or by following these steps:



1 **Go to MyBlue at myblue.bluecrossma.com. You can create a new account, sign in to your personalized MyBlue account, or continue without signing in.**

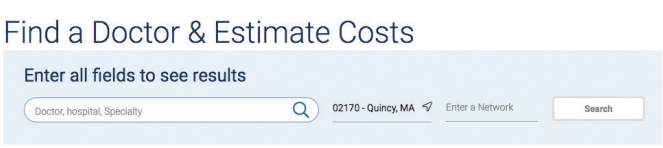


2 **Click Find a Doctor & Estimate Costs.**

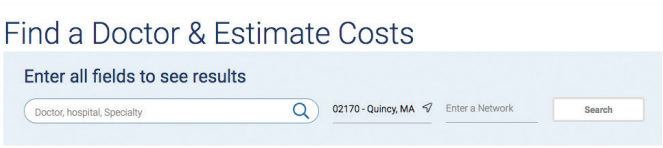
Find a Doctor & Estimate Costs

Questions?

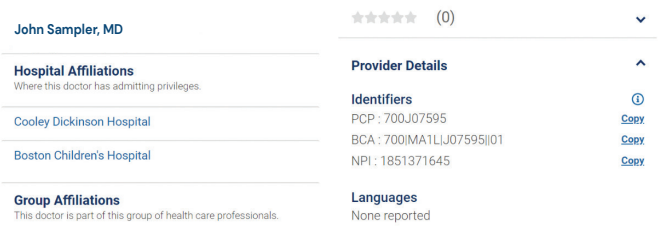
Call Member Service at **1-888-456-1351**. You can also find this number on the front of your ID card and in your Summary of Benefits.



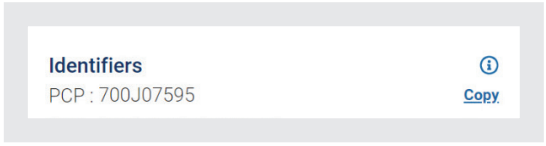
3 Enter your doctor's name, and your location. Select **Search** to bring up your doctor's profile page. When you sign in to **MyBlue**, your network information will appear. Otherwise, members with an HMO plan or Blue Choice® should select **HMO Blue** as the network.



4 If you don't have a PCP, you can search for one by entering **Primary Care** in the **Specialty** field. You can then sort based on location, ratings, languages spoken, or other attributes listed along the left-hand side of the page.



5 To find details about a provider, click the provider's name. Clicking on **Provider Details** will show the Identifiers, including the PCP's ID number.



MASSACHUSETTS

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.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
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**).
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**).

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

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**; 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**.

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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 Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (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**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε 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 ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

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

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (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**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

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