



Effective: 7/1/2022

WELCOME MIIA BERLIN-BOYLSTON RSD

New MIIA updates upon renewal in 2022

- The fitness and weight loss reimbursement has increased to \$300 each
- The cost share for the first 3 certain outpatient behavioral health visits per member will be waived on some plans

GET THE MOST OUT OF YOUR PLAN



VISIT MYBLUE



FIND A DOCTOR



LOOK UP A MEDICATION



CONTACT US



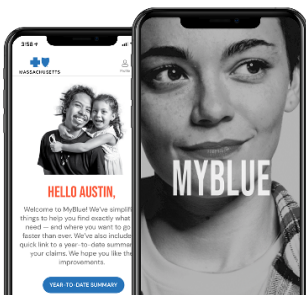
SAVINGS AND DEALS



DOWNLOAD THE MYBLUE APP



UNDERSTANDING YOUR PLAN AND BENEFITS



YOUR PLAN IN YOUR HAND

Get an instant snapshot of your health care.

Get Started

Register for MyBlue at bluecrossma.org or download the app.

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SUMMARY OF BENEFITS

NETWORK BLUE[®] NEW ENGLAND \$250 DEDUCTIBLE

MIIA Berlin Boylston
Regional School District

Plan-Year Deductible: \$250/\$750

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



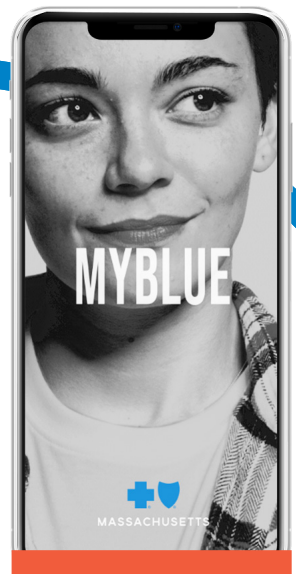
CLAIMS AND
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DIGITAL
ID CARD

Sign in

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



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.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

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.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$250** per member (or **\$750** 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 **\$2,500** per member (or **\$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** 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). After meeting your deductible, 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.

Value Care Offering Coverage

Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

Dependent Benefits

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

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
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 per calendar year)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> 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 \$30 per visit, no deductible
Mental health or substance use treatment	\$20 per visit, no deductible
Outpatient telehealth services <ul style="list-style-type: none"> With a covered provider With the designated telehealth vendor 	Same as in-person visit \$20 per visit, no deductible
Chiropractors' office visits	\$30 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$30 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$30 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$30 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$75 per category per service date after deductible
Home health care and hospice services	Nothing, no 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: <ul style="list-style-type: none"> 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 \$30 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$100 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$100 per admission after deductible†
Mental hospital or substance use facility care (as many days as medically necessary)	\$100 per admission, no 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.

*** 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.

† Deductible waived for mental health admissions.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies** (up to a 30-day formulary supply for each prescription or refill)***	No deductible \$10 for Tier 1 \$20 for Tier 2 \$35 for Tier 3
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)***	No deductible \$20 for Tier 1† \$40 for Tier 2 \$70 for Tier 3
<p>* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.</p> <p>** Specialty drugs available only when obtained from a designated specialty pharmacy.</p> <p>*** Cost share may be waived for certain covered drugs and supplies.</p> <p>† Certain generic medications are available through the mail order pharmacy at \$9. For more information, go to bluecrossma.org/mail-order-pharmacy.</p>	

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 fitness programs or equipment (See your benefit description for details.)

\$300 per calendar year per policy

Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)

\$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.

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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.emiia.org. 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 / \$750 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , prenatal care, <u>prescription drugs</u> , most office visits, mental health visits, therapy visits, emergency transportation, <u>home health care</u> , and <u>hospice services</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, \$2,500 member / \$5,000 family; and for <u>prescription drug</u> benefits, \$1,000 member / \$2,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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 <u>cost share</u> may be applicable
	<u>Specialist visit</u>	\$30 / visit; \$30 / chiropractor visit; \$30 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$75	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> 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 order supply	Not covered	Up to 30-day retail (90-day designated retail or mail order) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$20 / retail supply or \$40 / designated retail or mail order supply	Not covered	
	Non-preferred brand drugs	\$35 / retail supply or \$70 / designated retail or mail order supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$30 / visit	\$30 / visit	Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	Not covered	<u>Cost share</u> may be waived or reduced for certain services; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$100 / admission	Not covered	<u>Pre-authorization</u> required for certain services
If you are pregnant	Office visits	No charge	Not covered	<u>Deductible</u> applies first for childbirth/delivery facility services; <u>cost sharing</u> does not apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$100 / admission	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	<u>Home health care</u>	No charge	Not covered	<u>Pre-authorization</u> required
	<u>Rehabilitation services</u>	\$30 / visit for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first for inpatient services; limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$30 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth
	<u>Hospice services</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per calendar year
	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 per calendar year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$300 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 \$100
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$410

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 \$30
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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

- The plan's overall deductible \$250
- Specialist visit copay \$30
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$550

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

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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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NETWORK BLUE® SELECT \$250 DEDUCTIBLE

MIIA Berlin Boylston
Regional School District

Plan-Year Deductible: \$250/\$750

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



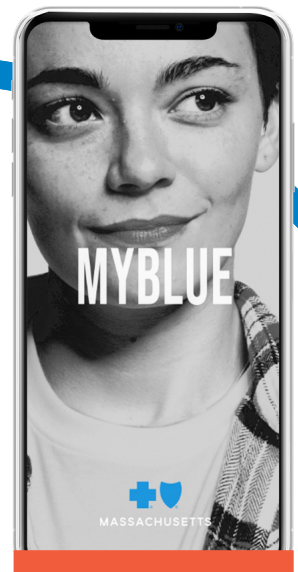
CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



This health plan includes a limited provider network called HMO Blue Select. It provides access to a network that is smaller than the Blue Cross Blue Shield of Massachusetts HMO Blue provider network. **In this plan, members have access to network benefits only from the providers in the HMO Blue Select network.** For help in finding which providers are included in the HMO Blue Select network, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.com/findadoctor and search for HMO Blue Select.



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 HMO Blue Select network of providers in Massachusetts. 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.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist within the HMO Blue Select network, who is likely affiliated with your PCP's hospital or medical group. You will not need prior authorization or referral to see an HMO Blue Select 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.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$250** per member (or **\$750** 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 **\$2,500** per member (or **\$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** 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). After meeting your deductible, 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 Massachusetts counties except Dukes, Barnstable and Nantucket.

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.

Value Care Offering Coverage

Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

Dependent Benefits

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

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
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 per calendar year)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> 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 \$30 per visit, no deductible
Mental health or substance use treatment	\$20 per visit, no deductible
Outpatient telehealth services <ul style="list-style-type: none"> With a covered provider With the designated telehealth vendor 	Same as in-person visit \$20 per visit, no deductible
Chiropractors' office visits	\$30 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$30 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$30 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$30 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$75 per category per service date after deductible
Home health care and hospice services	Nothing, no 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: <ul style="list-style-type: none"> 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 \$30 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$100 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$100 per admission after deductible†
Mental hospital or substance use facility care (as many days as medically necessary)	\$100 per admission, no 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.

*** 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.

† Deductible waived for mental health admissions.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies** (up to a 30-day formulary supply for each prescription or refill)***	No deductible \$10 for Tier 1 \$20 for Tier 2 \$35 for Tier 3
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)***	No deductible \$20 for Tier 1† \$40 for Tier 2 \$70 for Tier 3
<p>* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.</p> <p>** Specialty drugs available only when obtained from a designated specialty pharmacy.</p> <p>*** Cost share may be waived for certain covered drugs and supplies.</p> <p>† Certain generic medications are available through the mail order pharmacy at \$9. For more information, go to bluecrossma.org/mail-order-pharmacy.</p>	

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 fitness programs or equipment (See your benefit description for details.)

\$300 per calendar year per policy

Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)

\$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.

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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.emiia.org. 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 / \$750 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, prescription drugs, most office visits, mental health services, emergency transportation, home health care, and hospice services.	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, \$2,500 member / \$5,000 family; and for prescription drug benefits, \$1,000 member / \$2,000 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 <u>cost share</u> may be applicable
	<u>Specialist visit</u>	\$30 / visit; \$30 / chiropractor visit; \$30 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$75	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> 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 order supply	Not covered	Up to 30-day retail (90-day designated retail or mail order) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$20 / retail supply or \$40 / designated retail or mail order supply	Not covered	
	Non-preferred brand drugs	\$35 / retail supply or \$70 / designated retail or mail order supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$30 / visit	\$30 / visit	Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> 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)	\$100 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	Not covered	<u>Cost share</u> may be waived or reduced for certain services; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$100 / admission	Not covered	<u>Pre-authorization</u> required for certain services
If you are pregnant	Office visits	No charge	Not covered	<u>Deductible</u> applies first for childbirth/delivery facility services; <u>cost sharing</u> does not apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$100 / admission	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	<u>Home health care</u>	No charge	Not covered	<u>Pre-authorization</u> required
	<u>Rehabilitation services</u>	\$30 / visit for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first except for outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$30 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth
	<u>Hospice services</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per calendar year
	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 per calendar year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$300 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 <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$100
■ <u>Diagnostic tests copay</u>	\$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$410

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist visit copay</u>	\$30
■ <u>Primary care visit copay</u>	\$20
■ <u>Diagnostic tests copay</u>	\$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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist visit copay</u>	\$30
■ <u>Emergency room copay</u>	\$100
■ <u>Ambulance services copay</u>	\$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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$550

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

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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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SUMMARY OF BENEFITS

BLUE CARE ELECT \$250 DEDUCTIBLE

MIIA Berlin Boylston
Regional School District

Plan-Year Deductible: \$250/\$750

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



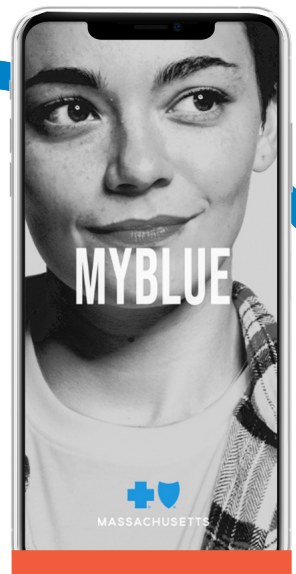
CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



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 most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$250** per member (or **\$750** 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 when you obtain covered services from preferred providers. These are called your “in-network” benefits. See the charts 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 use 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.

How to Find a Preferred Provider

To find a preferred provider:

- 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. See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. You may be responsible 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 **\$2,500** per member (or **\$5,000** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** 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). After meeting your deductible, 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 includes 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 for payment to the provider of the service. Refer to your benefit description for 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.

Value Care Offering Coverage

Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

Dependent Benefits

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • 10 visits during the first year of life • 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
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after 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	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for an observation stay)	\$100 per visit after deductible (copayment waived if admitted or for an observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, multi-specialty provider group, 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	20% coinsurance after deductible
Mental health or substance use treatment	\$30 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services <ul style="list-style-type: none"> • With a covered provider • With the designated telehealth vendor 	\$20 per visit, no deductible	Same as in-person visit Not applicable
Chiropractors' office visits	\$30 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	\$30 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$30 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$30 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$75 per category per service date after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing, no deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing, no deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**	40% coinsurance after deductible**
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: <ul style="list-style-type: none"> • 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 • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care 	\$20 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	\$30 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	\$100 per admission after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	\$100 per admission after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$100 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 (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.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies** (up to a 30-day formulary supply for each prescription or refill)***	No deductible \$10 for Tier 1 \$20 for Tier 2 \$35 for Tier 3	Not covered
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)***	No deductible \$20 for Tier 1† \$40 for Tier 2 \$70 for Tier 3	Not covered

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.

** Specialty drugs available only when obtained from a designated specialty pharmacy.

*** Cost share may be waived for certain covered drugs and supplies.

† Certain generic medications are available through the mail order pharmacy at \$9. For more information, go to bluecrossma.org/mail-order-pharmacy.

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 fitness programs or equipment (See your benefit description for details.)

\$300 per calendar year per policy

Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)

\$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.

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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.emiia.org. 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 <u>deductible</u>?	\$250 member / \$750 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, <u>prescription drugs</u> , emergency transportation, <u>home health care</u> , and <u>hospice services</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For medical benefits, \$2,500 member / \$5,000 family; and for <u>prescription drug</u> benefits, \$1,000 member / \$2,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric <u>specialist</u> , nurse midwife, limited services clinic, multi-specialty <u>provider</u> group, or by a physician assistant or nurse practitioner designated as primary care; a telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$30 / visit; \$30 / chiropractor visit; \$30 / acupuncture visit	20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit	<u>Deductible</u> 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 <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	\$75	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required

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 order supply	Not covered	Up to 30-day retail (90-day designated retail or mail order) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$20 / retail supply or \$40 / designated retail or mail order supply	Not covered	
	Non-preferred brand drugs	\$35 / retail supply or \$70 / designated retail or mail order supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$30 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>cost share</u> may be waived or reduced for certain services; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$100 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$100 / admission	20% <u>coinsurance</u>	

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	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required
	<u>Rehabilitation services</u>	\$30 / visit for outpatient services; No charge for inpatient services	20% <u>coinsurance</u> for outpatient services; 20% <u>coinsurance</u> for inpatient services	<u>Deductible</u> applies first except for in-network outpatient services; limited to 100 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$30 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable
	<u>Skilled nursing care</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth (20% <u>coinsurance</u> for out-of-network)
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> 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% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to one per calendar year
	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% <u>coinsurance</u> for members with a cleft palate / cleft lip condition	<u>Deductible</u> 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 | • Dental care (Adult) | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | |

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) | • Infertility treatment | • Routine foot care (only for patients with systemic circulatory disease) |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (\$300 per calendar year per policy) |
| • Chiropractic care | • Routine eye care - adult (one exam per calendar year) | |
| • Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger) | | |

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 <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$100
■ <u>Diagnostic tests copay</u>	\$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$410

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist visit copay</u>	\$30
■ <u>Primary care visit copay</u>	\$20
■ <u>Diagnostic tests copay</u>	\$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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist visit copay</u>	\$30
■ <u>Emergency room copay</u>	\$100
■ <u>Ambulance services copay</u>	\$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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$550

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

* Registered Marks of the Blue Cross and Blue Shield Association. © 2022 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



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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DENTAL BLUE[®] FREEDOM (WITH ORTHODONTICS)

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



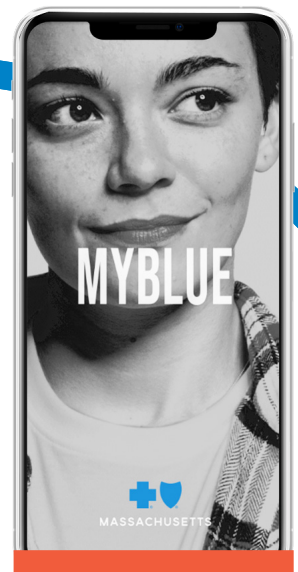
CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



DENTAL BLUE FREEDOM WITH ORTHODONTICS

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	\$25 Per Member/\$75 Per Family Calendar-Year Deductible (in-network and out-of-network combined)	
Full Coverage	80% Coverage	50% Coverage
\$1,000 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)		
<p>Diagnostic</p> <ul style="list-style-type: none"> 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 <p>Preventive</p> <ul style="list-style-type: none"> 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) 	<p>Restorative</p> <ul style="list-style-type: none"> 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) <p>Oral Surgery</p> <ul style="list-style-type: none"> Tooth extraction Root removal Biopsies <p>Periodontics (gum and bone)</p> <ul style="list-style-type: none"> 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 <p>Endodontics (roots and pulp)</p> <ul style="list-style-type: none"> 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 <p>Prosthetic Maintenance</p> <ul style="list-style-type: none"> Repair of partial or complete dentures, crowns, and bridges once each 12 months Adding teeth to an existing complete or partial denture Rebase or relines of dentures once each 36 months Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months <p>Other Services</p> <ul style="list-style-type: none"> 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* 	<p>Prosthodontics (teeth replacement)</p> <ul style="list-style-type: none"> 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) <p>Major Restorative (members age 16 or older)</p> <ul style="list-style-type: none"> 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 <p>Implants (members age 16 or older)</p> <ul style="list-style-type: none"> 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
Orthodontic Benefit Group		
50% coverage for members up to age 19		
No deductible		
<ul style="list-style-type: none"> Complete orthodontic exam Comprehensive or limited active orthodontic treatment, including appliances 		
\$1,500 Lifetime Benefit Maximum		

* Emergency care services are not subject to the calendar-year deductible.

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 dentists in Massachusetts and Rhode Island who participate with Blue Cross Blue Shield of Massachusetts. Dental Blue Freedom members also have access to participating dentists 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 Benefits

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 calendar-year deductible and coinsurance (if applicable), and 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 or lifetime benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year or lifetime 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 Dentists

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 deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year or lifetime benefit maximum.

How Network Dentists Are Paid – Participating Dentists

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 deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year or lifetime benefit maximum.

How Out-of-Network Dentists Are Paid – Non-Preferred or Non-Participating Dentists

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 deductible and coinsurance (if applicable), and charges beyond your calendar-year or lifetime benefit maximum.

Orthodontic Benefits

Your plan includes orthodontic coverage. The lifetime benefit maximum is not part of your calendar-year benefit maximum; it applies only to orthodontic services. You are responsible for your coinsurance (if applicable) and any charges beyond your lifetime benefit maximum. Benefits are available on your effective date. If your orthodontic treatment began before you were covered under Dental Blue Freedom, a monthly fee will be paid for your remaining orthodontic visits until either your treatment is completed or the lifetime benefit maximum is exhausted, whichever comes first.

When Coverage Begins

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

Dependent Benefits

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

Accumulated Maximum Rollover Benefits

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 Benefits

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 Claim

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 Information

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.



MASSACHUSETTS

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.

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

BLUE 20/20 MATERIALS ONLY STANDARD VISION PLAN: ACCESS NETWORK

Vision care service	In-network member cost	Out-of-network reimbursement ¹
Frames	\$130 allowance, then additional 20% off the balance	up to \$74
Standard plastic lenses <ul style="list-style-type: none"> • Single vision • Bifocal • Trifocal • Lenticular • Standard progressive lens • Premium progressive lens 	<ul style="list-style-type: none"> \$25 copay \$25 copay \$25 copay \$25 copay \$90 copay \$90 copay, then 80% of charge less \$120 allowance 	<ul style="list-style-type: none"> up to \$42 up to \$78 up to \$130 up to \$130 up to \$140 up to \$196
Lens options² <ul style="list-style-type: none"> • UV treatment • Tint (solid and gradient) • Standard plastic scratch coating • Standard polycarbonate • Standard polycarbonate for covered dependents under age 19 • Standard anti-reflective coating • Photochromic/Transitions[®] plastic • Polarized • Other add-ons 	<ul style="list-style-type: none"> \$15 \$15 \$15 \$40 Paid in full \$45 20% off retail price 20% off retail price 20% off retail price 	<ul style="list-style-type: none"> n/a n/a n/a n/a up to \$26 n/a n/a n/a n/a
Contact lenses³ <ul style="list-style-type: none"> • Conventional • Disposable • Medically necessary 	<ul style="list-style-type: none"> \$130 allowance, then additional 15% off the balance \$130 allowance Paid in full 	<ul style="list-style-type: none"> up to \$104 up to \$104 up to \$210
Frequency <ul style="list-style-type: none"> • Lenses for frames or one order of contact lenses • Frames 	<ul style="list-style-type: none"> once every 12 months once every 24 months 	

ADDITIONAL IN-NETWORK SAVINGS AND DISCOUNTS

40%

OFF A COMPLETE SECOND PAIR OF GLASSES

20%

OFF NON-PRESCRIPTION SUNGLASSES

15%

OFF RETAIL PRICE OR 5% OFF PROMOTIONAL PRICE FOR LASER VISION CORRECTION THROUGH U.S. LASER NETWORK

Blue 20/20 is administered by EyeMed Vision Care[®], an independent company.



For costs and further details about the coverage, including exclusions, refer to your member booklet.

1. Your actual expenses for covered services may exceed the stated out-of-network amount.
2. Indicates a service that is a discounted arrangement as part of your vision plan.
3. Discount applies to materials only and not to fittings for contact lenses.

BENEFITS YOU CAN SEE—FROM A COMPANY YOU TRUST



ACCESS TO ONE OF
THE NATION'S LARGEST
VISION NETWORKS



THOUSANDS OF
INDEPENDENT PROVIDERS



AWARD-WINNING
CUSTOMER SERVICE

FAVORITE NATIONAL RETAILERS

LENSCRAFTERS®

PEARLE^{OO}VISION™

 OPTICAL®

and many regional retailers.

ONLINE SHOPPING OPTIONS

- Glasses.com
- Contactsdirect.com
- Ray-Ban.com
- Targetoptical.com
- Lenscrafters.com



SPECIAL OFFERS FOR ADDITIONAL SAVINGS

Find them at blue2020ma.com.

SAVE ON HEARING EXAMS AND HEARING AIDS

Offered by Amplifon Hearing, an independent company. To learn more about the savings available, visit amplifonusa.com/blue2020. To get started, call 1-866-921-5367.

Questions?

Call customer service at 1-855-875-6948.

To locate an in-network provider, visit blue2020ma.com.*

*Registration not required to search for providers.

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.

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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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Mail Order Pharmacy

The Mail Order Pharmacy Saves You Time and Money



You can get 90-day prescriptions for certain maintenance medications delivered right to your door, and for a fraction of the cost, when you order them through the mail order pharmacy. Maintenance medications, also known as long-term medications, are prescribed to treat chronic or ongoing conditions, such as high blood pressure or diabetes.

Advantages of Using the Mail Order Pharmacy

- You'll pay less for a 90-day supply than you would for three 30-day supplies of your maintenance medications
- Medications are shipped to you at no additional cost for standard shipping
- With fewer refills and no trips to the pharmacy, you'll be less likely to miss a dose
- Get your prescriptions on time, every time with automatic refills

How to Order Prescriptions

Express Scripts®, an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts, will deliver your prescriptions straight to your door. To order prescriptions, choose one of the following options. In most cases, Express Scripts will contact your doctor directly to arrange 90-day prescriptions, plus refills.

- Visit Express Scripts at express-scripts.com/starthd, and select **Register**
- Download the Express Scripts mobile app and select **Register**
- Call Express Scripts at 1-800-892-5119 (TTY: 1-800-305-5376)
- Ask your doctor to e-prescribe a new, 90-day prescription to Express Scripts, or fax it to 1-800-837-0959
- Fill out the order form* and mail it to:
Home Delivery Service
PO Box 66566
St Louis, MO 63166-9967

How to Order Refills

- Log in to Express Scripts at express-scripts.com, select the medications to be filled, then click **Add to Cart**
- Call Express Scripts at 1-800-892-5119 (TTY: 1-800-305-5376), 24 hours a day

Have Your Prescriptions Refilled Automatically

Worry Free Fills® are available for qualifying maintenance medications. When enrolled, Express Scripts will calculate when you'll need your prescriptions and deliver them on time. They'll contact you before processing each fill to confirm delivery, and the delivery date. Enroll in Worry Free Fills by choosing one of the following methods:

- Visit Express Scripts at express-scripts.com, and select **Automatic Refills**
- When refilling a prescription, answer yes when asked to enroll in Worry Free Fills
- Call Express Scripts at 1-800-892-5119 (TTY: 1-800-305-5376)

Save up to
33%

When you use the mail order pharmacy.**

*You can download and print a copy of the mail order form at express-scripts.com.

**Compared to three 30-day prescriptions purchased at a retail pharmacy.



1042

REMINDER: This section must be removed before mailing.

Patient 1 (Cardholder)		Patient 2	
Name: _____		Name: _____	
<input type="radio"/> I want non-child resistant caps, when available.		<input type="radio"/> I want non-child resistant caps, when available.	
Date of Birth (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>		Date of Birth (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	
DRUG ALLERGIES	List other Allergies here:	<input type="radio"/> No Known Allergies Acetaminophen/Tylenol® Amoxicillin Aspirin Cephalosporin (i.e., Keflex®, Cephalexin) Codeine Erythromycin, Biaxin®, Zithromax® NSAIDs (i.e., Ibuprofen, Naproxen) Oxycodone (i.e., OxyContin®, Percocet®) Penicillin Sulfa Tetracycline (i.e., Doxycycline, Minocycline)	List other Allergies here:
	List other Health Conditions here:	<input type="radio"/> No Known Health Conditions Arthritis (715.9) Asthma (493.9) Chronic Bronchitis or Emphysema (496) Depression (311) Diabetes Type I (250.01) Diabetes Type II (250.00) Epilepsy/Seizures (345.9) GERD (530.81) Glaucoma (365.9) High Cholesterol (272.9) Hormone Replacement Therapy (627.9) Hypertension (401.9) Thyroid: Low (244.9)	List other Health Conditions here:
	List other OTC that you take on a regular basis:	<input type="radio"/> No Over-the-Counter Medications Acetaminophen/Tylenol® Advil®/Aleve®/Motrin® Aspirin/Excedrin®	List other OTC that you take on a regular basis:
	List Medical Devices here:	<input type="radio"/> No Medical Devices Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	List Medical Devices here:
	List other Prescription Medications here:	<input type="radio"/> No Other Prescriptions Prescription Medications not filled through Express Scripts Pharmacy.	List other Prescription Medications here:

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required _____

More than two family members on your plan? On a separate sheet of paper, write the family member(s) name, date of birth, allergies and health conditions along with the name and phone number of their doctor/prescriber.

Please Note: Your order may be filled at any one of our Express Scripts Pharmacies located nationwide.

Express Scripts Medication Mail Order Form

- ▶ **To order online:** visit express-scripts.com/starthd, select "Register"
 - To order by phone:** call 1-800-892-5119 (TTY: 1-800-305-5376)
 - To order using e-prescribe:** ask your doctor to e-prescribe your prescription, or fax it to 1-800-837-0959
 - To order by mail:** complete this form using capital letters and black ink, then mail it, along with a 90-day prescription (or the maximum supply allowed) to:
Home Delivery Service
PO Box 66566, St Louis, MO 63166-9967
- NOTE:** No cost standard shipping is included on all mail orders.



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PATIENT 1 (CARDHOLDER)

ID Card Number

First Name MI Date of Birth (MM/DD/YYYY)

Last Name Gender M F

Some medications cannot be delivered to a PO Box. Provide a street address to allow delivery of your order.

Shipping Address 1

Shipping Address 2

City State

Zip Code - Check here for rush shipment. Your order, once received and filled, will be shipped overnight for \$21.

Email

Please select one as your preferred telephone number

- Daytime Phone () -
- Evening Phone () -
- Cell Phone () -

Doctor/Prescriber Last Name Doctor/Prescriber Phone Number

PATIENT 2

First Name MI Date of Birth (MM/DD/YYYY)

Last Name Gender M F

Email

Doctor/Prescriber Last Name Doctor/Prescriber Phone Number

PAYMENT

All individuals included in the family will be charged to this credit card.

Apply to this order only Apply to all orders

Check Card Credit Card Check / Money Order

Card #

Sign here to authorize card payment

Amount Enclosed \$.

Exp. Date (MM/YY) /

Detach Here

Detach Here

For all orders after 08/01/2011, use this form. Fold and tear off this piece before putting in the return envelope.

Please note

Please note that all prescriptions requiring a formulary exception will not be processed without prior approval. To prevent any delays, make sure that an approved formulary exception (if applicable) is on file before you place your order.

Thank you for using our mail service prescription drug program.

MLRBENP



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 3580 ST LOUIS MO

POSTAGE WILL BE PAID BY ADDRESSEE

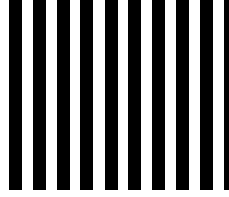


EXPRESS SCRIPTS®

Home Delivery Service
PO Box 66566
St Louis, MO 63166-9967



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



Did You Remember To...

- Complete all applicable information
- Include your ID number on the mail order form
- Enclose the original prescription, mail order form, and appropriate copayment
- Make checks or money orders payable to "Express Scripts", or include credit card information

Detach envelope to mail prescription order form



(Tear here)

Detach envelope to mail prescription order form



(Tear here)

Pref

Glue

Fold

Glue

Pref

Inside envelope

Glue

Fold

Glue

Glue

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MASSACHUSETTS

GET TO KNOW THE MEDICATION LOOKUP TOOL

With a simple search, you can see which medications your plan covers.

Our **Medication Lookup** tool lets you easily learn more about your coverage for prescription medications, including those with additional requirements like Prior Authorization. Search anytime, anywhere at bluecrossma.org or using the MyBlue app.



KEY FEATURES

Using the tool, you can:



SEARCH FOR ANY MEDICATION

See if it's covered by your plan



GET DETAILED INFORMATION

Including the medication's strength, tier, and how it's dispensed



VIEW ADDITIONAL COVERAGE REQUIREMENTS

Such as Prior Authorization, Step Therapy, and Quality Care Dosing



SEE COVERED ALTERNATIVES

For non-covered medications

Start Searching

For more information about your prescription coverage, sign in to MyBlue at bluecrossma.org or open the MyBlue app, and go to **Medication Lookup Tool** under **My Medications**. If you're not a member, you can get more information by visiting bluecrossma.org/medication.

GETTING COVERAGE INFORMATION, SIMPLIFIED

We're making it easier than ever for everyone to learn more about our medication coverage.

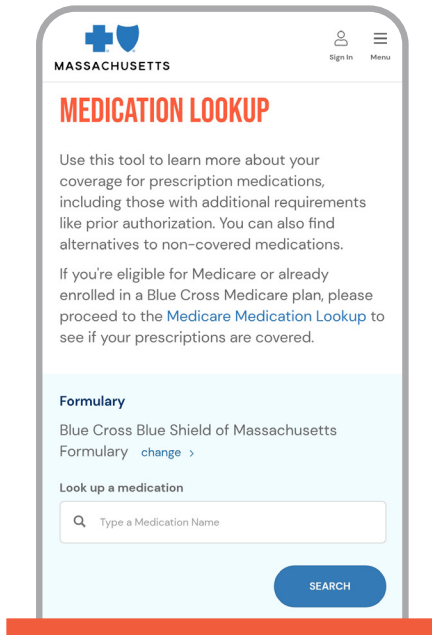
PERSONALIZED SEARCH

When you're signed in to your MyBlue account, your plan's formulary and tier structure will be automatically displayed in the tool. That way, you'll know you're getting the most accurate search results for your plan.

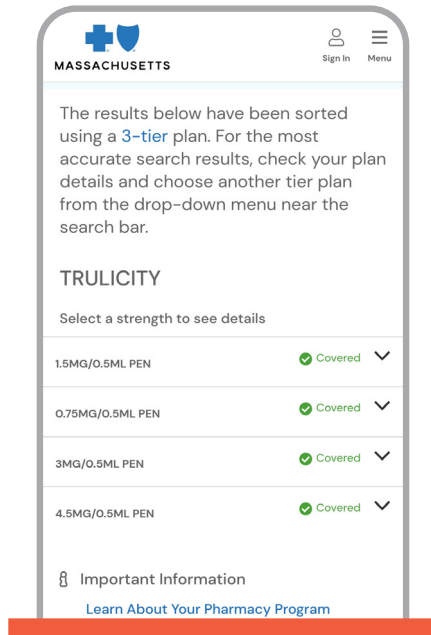
ANYONE CAN USE IT

The **Medication Lookup** tool is available to everyone, even if you aren't a member yet. You can easily find out if your medication is covered, or see covered alternatives, before you enroll.

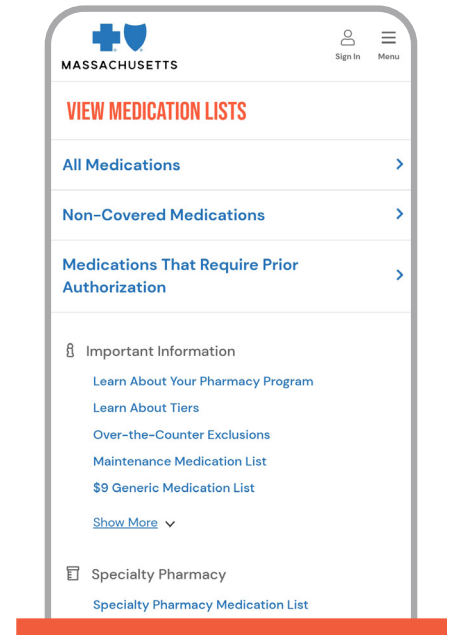
HOW TO USE THE TOOL



Sign in to MyBlue and go to the **Medication Lookup Tool** under **My Medications**. If you're not a member, go to bluecrossma.org/medication and choose the formulary you want to search. When not signed in, the tool will default to a 3-tier plan.



Select a medication to see if it's covered and get even more information, including strength and additional coverage requirements. Plus, if it's not covered, you can see covered alternatives.



Access important resources, like medication lists and Specialty Pharmacy Contact Information lists, in the **Important Information** and **Specialty Pharmacy** sections. If you're signed in to MyBlue, this list will be customized to match your benefits.

Learn More

To learn more about your pharmacy benefits, including which tier structure your plan uses, sign in to your MyBlue account at bluecrossma.org or check your plan materials for details.

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MASSACHUSETTS

THE CARE YOU NEED. WHENEVER AND WHEREVER.

You have more ways than ever to get expert medical opinions and advice. Right when you need them.



24/7 NURSE
LINE



VIDEO DOCTOR
VISIT



DOCTOR'S
OFFICE



LIMITED SERVICE
CLINICS



URGENT
CARE

Learn More

Visit bluecrossma.org to review your medical care options.

Go to the nearest emergency room, or call 911 when you're facing a life-threatening situation or think you could put your health in danger by delaying care.

KNOWING YOUR OPTIONS FOR CARE COULD SAVE YOUR TIME AND MONEY



24/7 NURSE LINE

When you're uncertain if your symptoms are serious or if an injury needs immediate care, get a nurse's advice 24/7, even on holidays. Call 1-888-247-BLUE (2583).

Best for: advice on when to seek care or questions about your symptoms, or whether they might be serious.

Cost:

Time:

Severity:



VIDEO DOCTOR VISIT

Get convenient medical and mental health care from licensed doctors, therapists, and psychologists using your favorite device. Sign in to the MyBlue app or visit bluecrossma.org, and click Well Connection.

Best for: colds, minor cuts, cough, wheezing, sore throat, headache or migraine, mild allergies, fever, skin rash, etc.

Cost:

Time:

Severity:



DOCTOR'S OFFICE

Visit your doctor for scheduled checkups and urgent health concerns that occur during office hours.

Best for: asthma, minor burns, nausea, urination problems, back pain, minor injuries, suspected flu, sinus infection, behavioral health, conjunctivitis or other eye irritation.

Cost:

Time:

Severity:



LIMITED SERVICE CLINICS

Found in local pharmacies, you can visit a limited service clinic for simple medical concerns.

Best for: cold and flu, bronchitis, sinus and respiratory infections, sore throat, diarrhea, gout, strep throat, urinary tract infections, pinkeye, hypertension, migraines, pneumonia.

Cost:

Time:

Severity:



URGENT CARE

Go to a nearby urgent care center when you need immediate, in-person help for a non-life-threatening problem and you can't see your doctor.

Best for: joint/muscle pain or injuries, nausea or diarrhea, respiratory issues, bites, cuts, concussion screening, stitches, asthma attack, X-rays, and suspected strep throat or bronchitis.

Cost:

Time:

Severity:

Find a Provider

To find a doctor, hospital, limited service clinic, or urgent care center near you, sign in to MyBlue at bluecrossma.org and go to **Find a Doctor & Estimate Costs**.

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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**

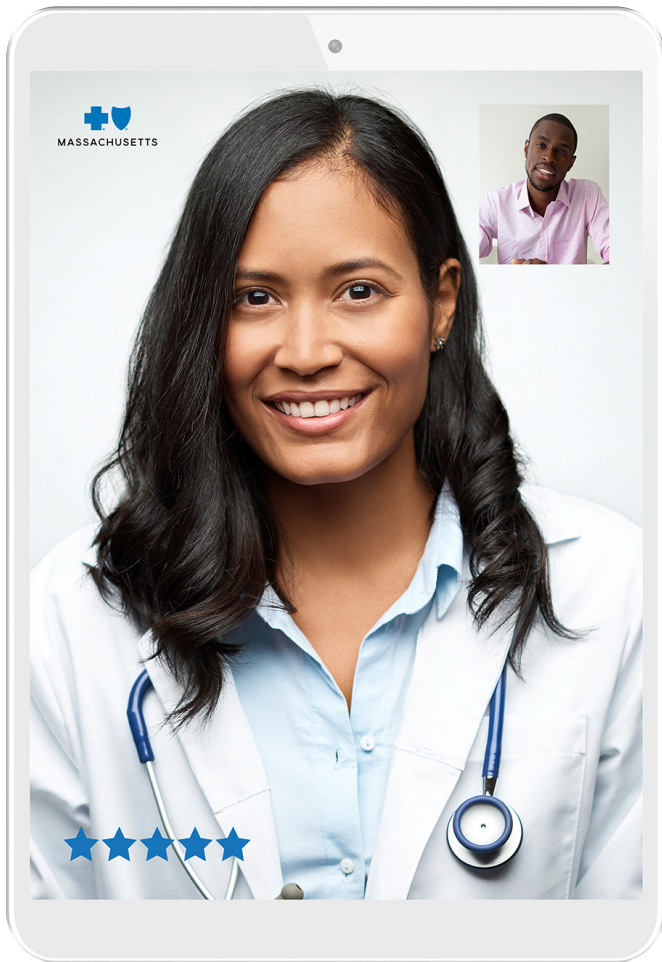
Qualified providers. Rated 4.8/5 stars and averaging 15 years of experience.²

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 members³

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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MASSACHUSETTS

HMO BLUE SELECT

Great Coverage,
Even Greater Savings.



The HMO Blue Select health plan has a limited provider network. This network is smaller than the Blue Cross Blue Shield of Massachusetts HMO Blue provider network. Under this plan, members have access to network benefits from only the providers in the HMO Blue Select network.

Need help?

For help determining which providers are included in the HMO Blue Select network, check the most current provider directory, or visit Find a Doctor at bluecrossma.com/findadoctor and select "HMO Blue Select".

WHAT IS IT?

A lower-cost, limited-network plan design, providing comprehensive care from the brand you trust.

HOW DOES IT WORK?

HMO Blue Select works like a traditional HMO, but with a limited set of network providers that deliver savings to both you and your employees.

This HMO Blue Select network includes doctors, facilities, and specialty hospitals that are recognized for providing lower-cost care. With HMO Blue Select, members still require referrals for access to specialists and are also required to select a primary care provider. To get the most out of their plan, members should use the more cost-effective providers in the HMO Blue Select network, except in an emergency when they should go to the nearest medical facility.

HOW YOU SAVE

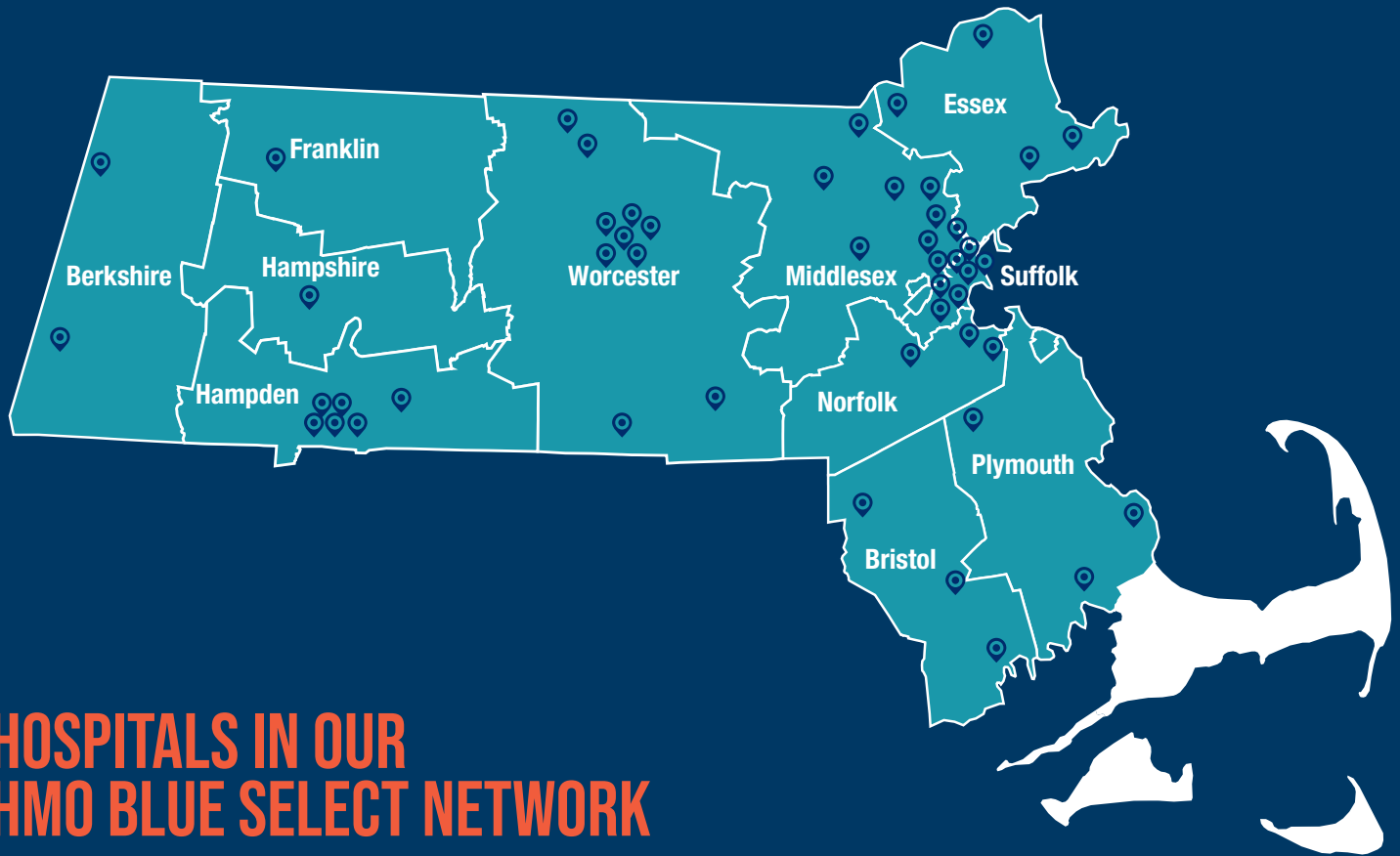
Getting the most value out of your plan is simple—your employees get care at lower-cost providers in the HMO Blue Select network. The savings will be reflected in lower health care costs for you.

Key Features	Your Advantages
Members have access to a local provider network of cost-effective doctors and hospitals they recognize and trust.	A Limited Network with Great Value HMO Blue Select features a smaller and very attractive provider network with recognized Massachusetts doctors and hospitals, as well as specialty pediatric, eye, ear, and cancer hospitals, keeping employer and employee affordability in mind.
Hospitals are aligned with provider networks to improve network use.	A Seamless, Low-Cost Experience HMO Blue Select offers a full range of network services by tailoring the network to include doctors and the hospitals they typically refer, to ensure an end-to-end, low-cost advantage.
Predominantly, HMO Blue Select providers are contracted in our results-based accountability model.	Results-Driven Provider Relationships We're focused on results, and we're supporting and motivating providers to deliver care that works better.
You can lower benefit costs without having to increase employee cost-sharing responsibility.	Same Employee Cost Sharing with Lower Costs HMO Blue Select offers employees noticeably lower health care costs when compared to a similar full HMO network plan, without increasing their cost sharing. As a result, accounts can keep the same benefit plans and pay less in costs.
In the case of emergencies, members have national access to the nearest medical facility without network restrictions.	In Emergencies, Nationwide Access HMO Blue Select allows members, whether they're traveling or on vacation, to see providers nationwide for emergency and urgent care.
The same great service from the brand you trust.	Lower Cost. Excellent Service. Trusted Brand. You and your employees will receive the same high levels of service and support that you've come to trust from Blue Cross.

ACCESS TO CARE ACROSS THE COMMONWEALTH

With the HMO Blue Select network, employees enjoy peace of mind knowing they can go to any of the network hospitals on the map below.

These hospitals have been carefully selected, based on their location and cost.



HOSPITALS IN OUR HMO BLUE SELECT NETWORK

Berkshire

- Berkshire Medical Center
- Fairview Hospital

Bristol

- Southcoast—Charlton Memorial Hospital
- Southcoast—St. Luke's Hospital
- Sturdy Memorial

Essex

- Addison Gilbert Hospital
- Anna Jaques Hospital
- Beverly Hospital
- Lawrence General Hospital

Franklin

- Baystate Franklin Medical Center

Hampshire

- Cooley Dickinson Hospital

Hampden

- Baystate Medical Center
- Baystate Wing Hospital
- Holyoke Medical Center
- Mercy Medical Center
- Noble Hospital
- The Hospital for Children—Springfield

Middlesex

- Cambridge Health Alliance—Cambridge Campus
- Cambridge Health Alliance—Somerville Campus
- Cambridge Medical Center
- Lahey Hospital and Medical Center
- Lowell General Hospital (includes the campus formerly known as Saints Medical Center)
- Marlborough Hospital
- MetroWest Medical Center—Framingham Union Hospital
- Winchester Hospital

Norfolk

- Beth Israel Deaconess Medical Center—Milton
- Beth Israel Deaconess Hospital—Needham
- South Shore Hospital

Plymouth

- Beth Israel Deaconess Medical Center—Plymouth
- Signature Healthcare Brockton Hospital
- Southcoast Hospitals Group—Tobey Hospital

Suffolk

- Beth Israel Medical Center
- Boston Children's Hospital
- Boston Medical Center
- Cambridge Health Alliance—Whidden Campus
- Dana-Farber Cancer Institute
- Massachusetts Eye and Ear Infirmary
- New England Baptist Hospital
- The Shriners Hospital for Children—Boston

Worcester

- Athol Memorial Hospital
- Clinton Hospital
- Harrington Memorial Hospital
- HealthAlliance Hospitals—Burbank Campus
- HealthAlliance Hospitals—Leominster Campus
- Heywood Hospital
- Milford Regional Medical Center
- Saint Vincent Hospital
- UMass Memorial Medical Center—Memorial
- UMass Memorial Medical Center—University



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MASSACHUSETTS

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 complete program that focuses on at-risk members with qualifying medical conditions. 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	✓	✓		
ORAL CANCER	✓		✓	✓
SJÖGREN'S SYNDROME	✓		✓	✓

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.

Please Note: Service frequencies displayed in the chart are effective on renewal starting April 1, 2021. For renewals prior to this date, these services are covered at the following frequencies: cleaning or periodontal maintenance every three months; periodontal scaling, once per quadrant every 24 months; oral cancer screening every six months; and fluoride treatment every three months. Condition-specific eligibility requirements must be met to receive coverage. Certain dental plans cover preventive dental services and Enhanced Dental Benefits at different frequency intervals. Please check your plan benefits to confirm your coverage before scheduling dental services.

NO ADDITIONAL COST TO RECEIVE THESE EXTRA SERVICES*

Enhanced Dental Benefits are included with your dental coverage, at no additional cost. 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 be subject to co-insurance.

*Qualifying members only.

Questions?

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

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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 98 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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Dental Blue®

Dental Blue® Service Map

No matter where your employees are in the country, they'll be able to find network dentists and providers.

Dental Blue Network

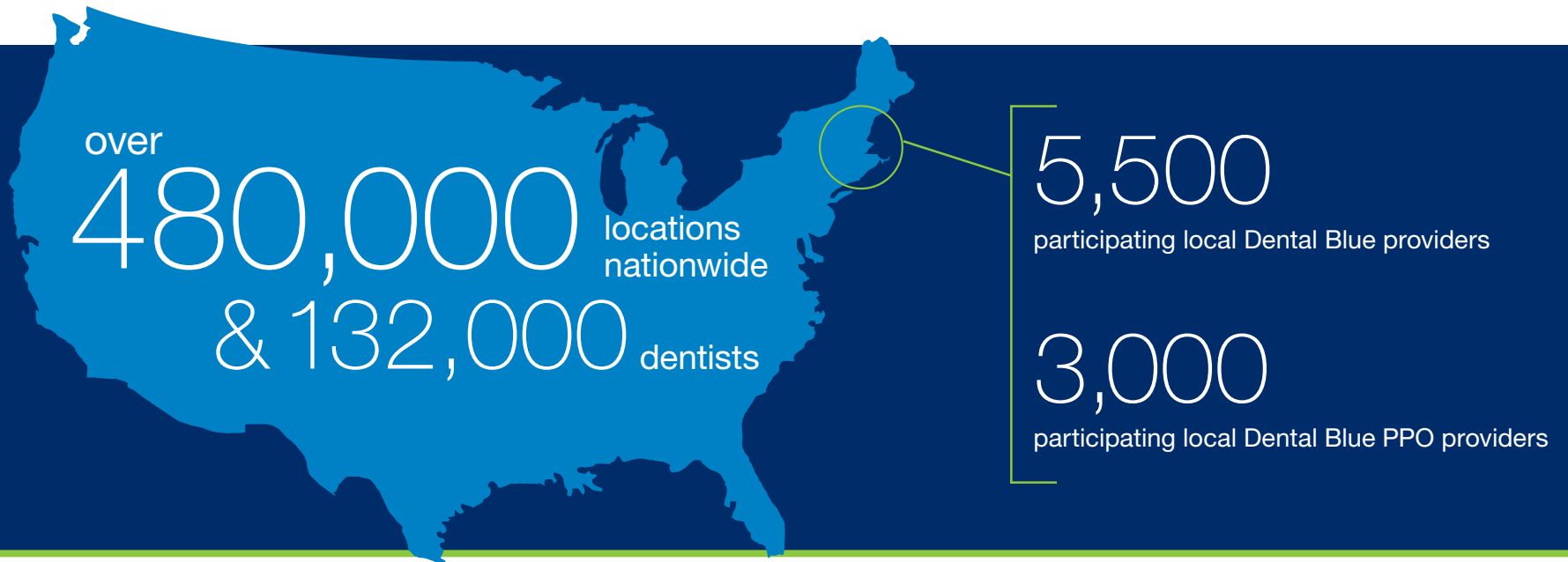
Our traditional network offers access to more than 95 percent of dentists in Massachusetts.

Dental Blue® PPO Network

Employees in our PPO plan will receive the most coverage when they see one of the thousands of dentists in Massachusetts who participate in our PPO network.

Nationwide Network Access

Dental Blue members have access to more than 480,000 credentialed provider locations nationwide.



The numbers of locations and unique dentists are accurate as of 3/1/21.

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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).

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MATERNITY CARE

Supporting you through pre-conception, pregnancy, childbirth, and caring for your new baby

Have questions about getting pregnant, pregnancy, labor, and what to expect during baby's first year? We're here to help you with a full range of maternity programs and benefits. We encourage you to explore all your benefits for starting and growing your family.



Ovia Pregnancy App

We're partnering with Ovia Health™—developer of the Ovia Pregnancy app—to give our members tools to support conception and healthy pregnancies. Go to oviahealth.com to download.



Living Healthy Babies®

Our **Living Healthy Babies** website is there when you need it, providing answers, educational resources, and interactive tools—including guidelines for recommended doctor visits. From preparing for pregnancy, being pregnant, going through delivery, and what to expect during baby's first year, we're here to guide you each step of the way. Learn more at livinghealthybabies.com.



Call-in Maternity Support

We offer specialized pregnancy and post-partum support to improve your health and help avoid complications. Call a Care Manager at **1-800-392-0098** Monday through Friday, 8:30 a.m. to 4:30 p.m. ET. For high-risk pregnancies, Nurse Care Managers are available.



Breast Pumps

New mothers can get a cost-free manual or dual electric breast pump. Learn more at bluecrossma.com/breast-pump.



Childbirth Course Reimbursement

Expectant mothers may be eligible for reimbursement up to \$90 for completing a childbirth course. Check with your employer or call Member Service at the number on your ID card to see if you have this benefit.



Call-in Maternity Depression Care

Many women may experience anxiety, mood swings, and crying spells known as "baby blues," but these feelings usually go away in a week or two post-delivery. Others experience a more serious condition called postpartum depression, which can last up to a year. Our Maternity Depression program provides support, education, and treatment referral for pregnant women and new mothers who may be struggling with these symptoms. For help, call a Behavioral Health Care Manager at **1-800-524-4010, ext. 62398**, Monday through Friday, 8:30 a.m. to 4:30 p.m. ET.

Learn More

Get started at bluecrossma.org/maternity.

FIND CARE



24/7 Nurse Line

If you have concerns about a health issue, call the 24/7 Nurse Line. A nurse can answer your medical questions and help you decide where to get the right care. Call **1-888-247-BLUE (2583)**.



Find a Doctor

To find a doctor or hospital near you, use our **Find a Doctor & Estimate Costs** tool, or call **1-800-588-5507** for help, Monday through Friday, 8:00 a.m. to 9:00 p.m. ET.



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MASSACHUSETTS

STOPPING THE FLU STARTS WITH YOU

Get your no-cost¹ flu shot!

If you haven't gotten your flu shot yet, now's the time. It will help protect you and everyone around you from getting sick, especially young children and older adults who are most at risk. The Centers for Disease Control and Prevention (CDC) says that it's safe,² effective, and can be given at the same time as the Covid-19 shot or booster. Get your no-cost¹ flu shot at a convenient location near you. We're in this together!



WHERE TO GET YOUR SHOT



FLU SHOT PROVIDERS

- Your In-network Primary Care Provider
- Limited Service Clinics (such as a MinuteClinic[®] at CVS[®])
- Urgent Care Centers
- Community Health Centers
- Public Access Clinics (available in some cities and towns and may be available at no charge)
- Hospital Outpatient Departments
- Skilled Nursing Facilities, for members in outpatient care, like physical or occupational therapy
- Home Health Care Providers (in your home, or at a flu clinic hosted by a home health care provider)
- Certified Nurse/Midwife's Office
- Physician Assistant's Office or Specialist Physician's Office
- Nurse Practitioner's Office
- Pharmacies



FIND A FLU SHOT PROVIDER NEAR YOU

- Visit [vaccines.gov](https://www.vaccines.gov) and click **Find Flu Vaccines** at the top of the page.
- To verify the provider is in-network, sign in to MyBlue or create an account at [bluecrossma.org](https://www.bluecrossma.org) and click **Find a Doctor & Estimate Costs**.
- If you need additional help, call Team Blue at **1-800-262-2583**.

Myth:

“I don't need the flu shot if I'm vaccinated for COVID-19.”

Learn fact from fiction at [bluecrossma.org/flu](https://www.bluecrossma.org/flu).

1. Flu vaccines recommended by the Centers for Disease Control and Prevention (CDC) are covered in full when administered by an in-network provider. Exceptions may apply. Check plan materials for details.

2. Centers for Disease Control and Prevention, "Influenza (Flu) Vaccine Safety," August 25, 2022; cdc.gov/flu/prevent/vaccinesafety.htm.

YOUR BEST SHOT AT AVOIDING THE FLU

To prevent getting sick, make the following steps part of your routine:



GET YOUR
FLU SHOT



AVOID CLOSE
CONTACT WITH
PEOPLE WHO
ARE SICK



WASH YOUR HANDS
FREQUENTLY



AVOID TOUCHING
YOUR EYES, NOSE,
AND MOUTH



GET PLENTY OF
REST, EXERCISE,
FLUIDS, AND GOOD
NUTRITION

TIPS FOR GETTING YOUR SHOT

- Make an appointment ahead of time, if possible, to avoid a wait.
- If the location doesn't take appointments, call and ask when slower times of the day/week are—try to go then.
- Pharmacies inside big-box retail chains and grocery stores, or local independent pharmacies, may be less busy than standalone pharmacies for flu shots.



LEARN MORE

Just about everyone six months and older should get the flu shot. If you aren't feeling well or have a health condition, talk to your doctor before getting vaccinated. Learn more about the flu and the flu shot at bluecrossma.org/flu.



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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FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

\$300



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!

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): <input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Spouse (of policyholder) <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Dependent (up to age 26) <input type="checkbox"/> 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

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).

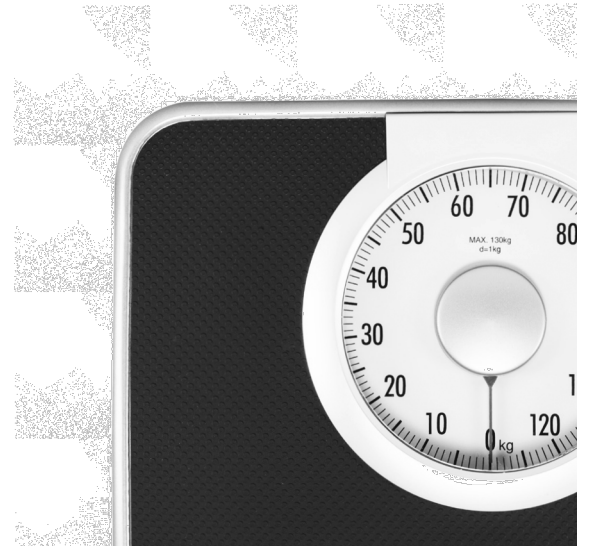
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

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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WEIGHT-LOSS REIMBURSEMENT

Your reward for healthy behavior: Receive up to \$300 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) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth __/__/__
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Claim is for (choose one and color in the entire box): **Name, Address, and Phone Number of Qualified Weight-Loss Program**

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

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.

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

MIIA Nonprofit
Locally based
Member driven
Serving Massachusetts' communities since 1982

THE RIGHT PLAN FOR YOUR NEEDS

Great Coverage
from Head to Toe



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

WE'VE GOT YOU COVERED

Blue Cross Blue Shield of Massachusetts and MIIA are proud to offer MIIA members and their families best-in-class, comprehensive medical and dental coverage, with unique tools and benefits for living a healthy lifestyle.



Medical

Enjoy the high-quality coverage you expect from Blue Cross, plus special benefits.



Dental Blue® Freedom

Receive coverage for regular dental checkups and more, from one of the largest networks in the country.

**The best plan is the kind you understand.
Use this guide to learn how to make the most of your benefits.**

IN THIS GUIDE:

- Preventive Care and Screenings 2
- Wellness Savings 3
- Finding Care 4
- Mental Health Care 5
- Pharmacy 6
- Family Planning Tools and Benefits 7
- Additional Tools and Resources 8
- Dental Blue® Freedom 9
- Blue 20/20 10
- Care Management 10
- COVID-19 Resources 11
- Contact Us 12

ABOUT MIIA HEALTH BENEFITS TRUST

- Established in 1992, MIIA (The Massachusetts Interlocal Insurance Association) is the insurance arm of the MMA (Massachusetts Municipal Association).
- Largest municipal joint purchase collaborative in the Northeast and one of the largest in the country
- Comprised of more than 150 cities, towns, school districts, and water districts, under M.G.L. Chapter 32B
- Over 46,000 subscribers (active employees and retirees)
- Over 83,000 members (active employees, spouses, dependents, and retirees)

Our Mission: To unite MA municipalities for the purpose of creating stable, secure, and affordable insurance programs of the highest quality to our membership community.

What Makes MIIA Different:

- Member-driven organization with the goal of providing stability over time
- 30-year partnership with Blue Cross
- Annual rate range with maximum rate caps, no matter how adverse a group's experience may be
- Large claim pooling at the \$75,000 level
- Low administrative costs

DON'T MISS OUT ON PREVENTIVE CARE

Your plan comes loaded with great features, including preventive screenings and evaluations that can help you manage your health. Take a minute to schedule your care now.

You're covered for these essentials at no additional cost:

- Routine health checkups
- Routine gynecological visits
- Immunizations for you and your family
- Cancer screenings like mammograms and colonoscopies
- Depression screenings
- Obesity screenings
- Tobacco and alcohol use evaluations

Mammograms

Breast cancer can be found with an imaging test known as a mammogram. Women ages 50 and older should have mammograms every two years, but mammograms can be performed before age 50 based on individual risk.

Colonoscopies

Colon cancer is the second-leading cause of cancer-related deaths, but may be cured or even prevented with regular screening and early detection. There are four colon cancer screenings — ask your doctor which screening they recommend.



Talk to your doctor about which screenings are right for you, based on your age, health risks, family history, and gender.

GET MOVING ON SAVINGS

We reward you for living a healthy lifestyle.



Fitness Reimbursement — \$300

Get reimbursed when you pay for membership fees at qualified health clubs, fitness classes (like yoga, Pilates, or spin), and virtual fitness (includes virtual/online fitness memberships, subscriptions, programs, or classes that provide cardiovascular and strength training using a digital platform) You can also get reimbursed when you purchase qualified home fitness equipment, like free weights and stationary bikes



Weight-Loss Reimbursement — \$300

Get reimbursed for eligible weight-loss programs, including WW (formerly Weight Watchers™) in-person and hospital-based programs, and WW online and other non-hospital programs that combine healthy eating, exercise, and coaching sessions with certified health professionals.

For more details, go to bluecrossma.org.

Blue365®

Get exclusive discounts and savings on:

- Fitness gear and equipment
- Nutrition deals
- Health and fitness clubs
- Much more

For more details, go to blue365deals.com.

Save up to 30% on standard rates at in-network alternative health providers, through our Living Healthy NaturallySM program.

THE CARE YOU NEED. WHENEVER AND WHEREVER.

You have more ways than ever to get expert medical opinions and advice, right when you need them.

You should always go to the nearest emergency room or call 911 in a life-threatening situation. However, for other situations, including urgent care, these options can save you time and money:

Primary Care Provider (PCP)

Unless it's a true emergency, it's best to call your PCP's office first, when you're sick or injured, even after hours.



Limited Service Clinics

These are clinics, such as CVS[®] Minute Clinic[®], that are located in local pharmacies. They can treat you for minor medical concerns without an appointment or referral. They're often open seven days a week with evening hours.

Urgent Care Centers

Use these facilities for treatment of serious but not life-threatening conditions. No referral is necessary for in-network centers. They're often open seven days a week with evening hours.

» To find a Limited Service Clinic or Urgent Care Center:

1. Download the [MyBlue](#) app, or create an account at [bluecrossma.org](#).
2. Go to the [Find a Doctor & Estimate Costs](#) tool.
3. Update your location and network if necessary, then search for **Clinics, Limited Service, or Urgent Care Center**.

24/7 Nurse Line

No additional cost for members

Talk to a registered nurse, at no additional cost, anytime you're sick or injured. They'll guide you through your next steps for care, whether it means treating yourself at home, visiting your PCP, or going to an emergency room, urgent care center, or limited service clinic.



Well Connection

When you need convenient access to care, use Well Connection. Choose from a network of telehealth providers for your medical and mental health needs,¹ with easy access via your computer or mobile device.

Access Well Connection
Through MyBlue
Click Well Connection
Video Visits under My Care.

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 available only in the United States.

MENTAL HEALTH IS HEALTH

We're making mental health care more available, to more members, in more ways, than ever before.

Mental Health Resource Center

Nothing should stand between you and your mental wellness, whether that means emotional, psychological, or social well-being. Our Mental Health Resource Center is the place to explore your care options, insightful information, and helpful wellness choices. You can:



Explore Your Options

Learn how to find an in-network therapist or treatment for a substance use disorder.



Check Out Current Topics

See articles and videos on coping with today's mental health challenges.



Use Your Benefits

Tap into all of your mental health care benefits with MyBlue.

LET TEAM BLUE LEND A HAND

To access the Mental Health Resource Center, go to [bluecrossma.org](#).

Learn to Live[®]

Learn to Live's personalized online experience is confidential, self-guided, and easy to use, and it comes at no cost. It's designed by the behavioral health specialists from Learn to Live, an independent partner company, to help you assess and explore your feelings, thoughts, emotions, and mind.

Use the tool as often as you like, 24/7, with programs to support:

- Stress, anxiety, and worry
- Depression
- Insomnia
- Substance use
- Social anxiety

Sign in to MyBlue, then click **Online Mental Health Tool** under **My Plan and Claims** to get started.

Opioid Resource Center

Seeking support for substance use disorder is never easy. We're here for you and your loved ones, with no judgment, no matter what you're going through. Our Opioid Resource Center has information to guide you through each step, from prevention to recovery. Learn more about fighting the opioid crisis, including how to use Narcan[®], the overdose reversal medication that's available to all members at no cost.



For more information, go to [bluecrossma.com/opioid](#).

THE PRESCRIPTION FOR A HEALTHIER YOU

Get to know your pharmacy benefits and all the ways you can save on your medications.

Preventive Medications with No Out-of-Pocket Costs

You can get certain medications used to prevent health conditions at no additional cost — no copayment, no co-insurance, and no deductible. These medications include iron and folic acid supplements, generic aspirin, smoking-cessation aids, tamoxifen (breast cancer), and raloxifene (osteoporosis).

\$9 Generic Medications

You can pay just \$9 for certain generic medications when you order a 90-day supply through the mail order pharmacy. Generic medications meet the same U.S. Food and Drug Administration (FDA) requirements as their brand-name counterparts, but are typically less expensive.

Save Time and Money with Smart90[®]

With Smart90, you can get 90-day supplies of certain maintenance medications, also known as long-term medications, from a CVS Pharmacy[™] location or through the mail order pharmacy for less than you'd pay for three 30-day supplies. To get started, call Express Scripts[®], an independent company that administers your pharmacy benefit, at 1-800-892-5119 (TTY: 1-800-305-5376).

For more information about your pharmacy benefits, go to bluecrossma.org.



GOOD FAMILY PLANNING STARTS WITH A GOOD PLAN

From managing fertility or infertility, to planning your pregnancy, birth control, or prenatal health, our tools and resources can help guide you through every step.

Take Advantage of Maternity Savings and Reimbursements

- **Get a breast pump at no additional cost:** Expectant mothers can order a manual pump or dual electric pump and have it delivered directly to their home at bluecrossma.org.
- **Childbirth class reimbursement:** If you pay to attend a childbirth class, you could get a reimbursement of up to \$90 upon completion.

Get the Facts with Living Healthy Babies[®]

Let Living Healthy Babies help make your journey through parenthood the healthiest it can be. This online resource offers facts and essentials for parenthood to help you before you conceive, during pregnancy, and after your baby is born. Get detailed information about:

- Planning a pregnancy
- What to expect each trimester
- Postpartum and newborn care

 Visit livinghealthybabies.com.

Your Pregnancy Comes with a Nurse

Get dedicated maternity support.

Call Team Blue to connect with a maternity nurse care manager, and get instant answers at no cost, Monday to Friday, 8:30 a.m. to 4:30 p.m. ET.

Call 1-800-392-0098.

Get a nurse's opinion 24/7.

Don't let questions keep you up at night. For concerns that can't wait, our general 24/7 Nurse Line is always on call.

Call 1-888-247-BLUE (2583).

Learn more about your maternity benefits at bluecrossma.org.

ADDITIONAL TOOLS AND RESOURCES

MyBlue

MyBlue is your key to managing your plan. Use it to access tools and resources, track your costs, find the answers you need, and more.



Review Coverage



Track Claims & Benefits



Submit Fitness & Weight-loss Reimbursements



Look Up Medications

Get Started

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



StepIn™ Weight Management Program

StepIn is virtual weight management program designed to help you build long-lasting, healthy habits that can improve your overall wellness. It combines one-on-one coaching with the tracking tools, clinical insights, and expert support you need to develop a healthier lifestyle.



To learn more about StepIn, go to stepin.livongo.com.

SmartShopperSM

SmartShopper is an incentive and engagement program managed by Sapphire DigitalSM, an independent company. Each time you or your covered dependents use an eligible, lower-cost health care provider for a qualifying medical procedure — like a mammogram or colonoscopy — you'll earn up to a \$250 cash reward, and save money on medical costs. To earn the reward, you must use the SmartShopper tool before having the procedure.

To use the SmartShopper tool, open the MyBlue app or sign in at bluecrossma.org to use our Find a Doctor & Estimate Costs tool.

DENTAL INSURANCE TO SMILE ABOUT

Maintaining a healthy smile can contribute to your overall health. So we designed a plan to keep your teeth in the best shape possible.

Dental Blue[®] Freedom

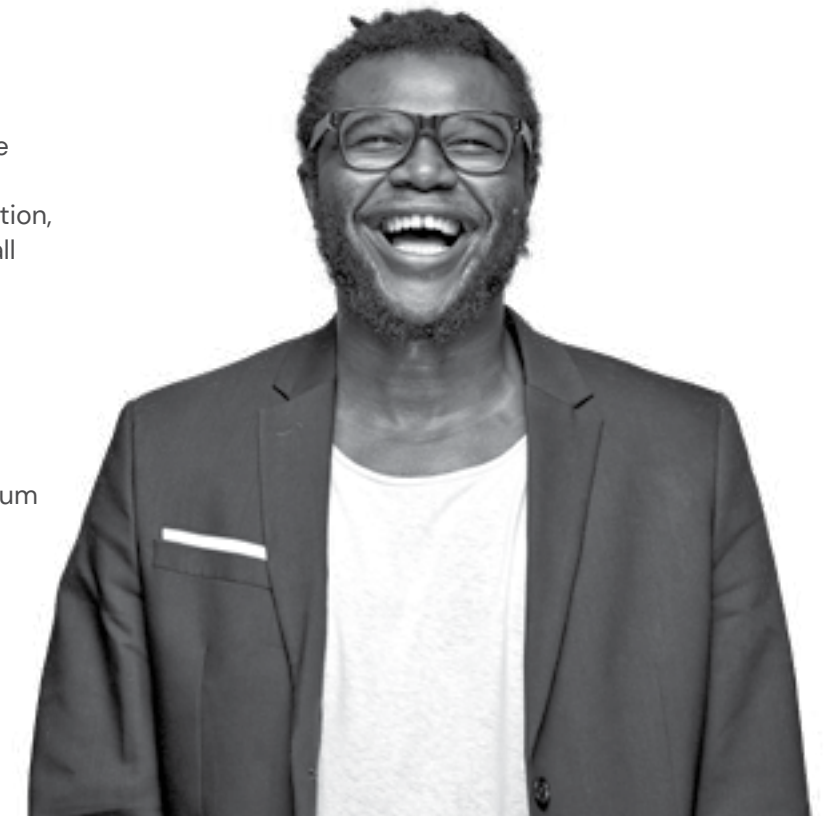
Offering members the ability to see any dentist in our Dental Blue[®] and Dental Blue[®] PPO networks, as well as out-of-network dentists, Dental Blue Freedom gives you the most choice for dental care. You'll get the best rates when you get care from an in-network dentist.

Your coverage includes two fully covered preventive dental cleanings every calendar year. These cleanings won't cost you anything out of pocket when you and your family visit an in-network dentist.

Enhanced Dental Benefits

If you have a qualifying medical condition,² you may be covered for additional preventive dental benefits, including extra services that can help prevent oral infection and inflammation, and have been connected to improved overall health. These benefits include:

- Cleaning or periodontal maintenance every three months
- Periodontal scaling and root planing
- No deductible, co-insurance, or copay
- Visits covered outside the annual maximum



To search for a dentist near you, open the MyBlue app or sign in at bluecrossma.org to use our Find a Doctor & Estimate Costs tool, or go to bluecrossma.com/findadoctor.

2. Qualifying conditions include diabetes, coronary artery disease, stroke, pregnancy, oral cancer, and Sjogren's syndrome.

SET YOUR SIGHTS ON TOP-NOTCH VISION COVERAGE

We partner with EyeMed Vision CareSM, an independent vision benefits company, to bring you more choice, more value, and more flexibility. Our convenient and affordable Blue 20/20 vision care plans feature:

- Access to one of the nation's largest vision networks
- Affordable premiums
- Routine exams
- Exclusive savings on designer frames, premium lenses and coatings, and contact lenses
- Award-winning customer service

More Choice, More Value, More Savings

- Laser vision correction: 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures
- 40% off additional eyewear purchases
- 20% off non-prescription sunglasses
- 20% off supplies, such as contact lens solution

Learn more about your vision benefits at blue2020ma.com.

PERSONALIZED SUPPORT IS A PHONE CALL AWAY

Our Care Management program offers specialized, ongoing support for our members at no additional cost.

You'll have direct access to a team of clinicians, including registered nurses, social workers, and dietitians, who provide support in addition to the regular care you get from your doctor. Your personalized Care Manager can help you manage chronic conditions like asthma, diabetes, and mental health needs, and complex medical conditions like cancer or multiple sclerosis. They can also:

- Assess your health needs
- Teach you about your condition and medications, and how to manage your symptoms
- Help you understand your doctor's treatment plan and your care options
- Work with you to develop your health goals
- Partner with your health care team to coordinate your care
- Provide resources to help you make informed health care decisions
- Help you get the most from your Blue Cross benefits



To talk to a Team Blue Care Manager, call 1-800-392-0098, Monday to Thursday, 8:30 a.m. to 8:00 p.m. ET, and Friday, 8:30 a.m. to 4:30 p.m. ET.

YOUR PLACE FOR COVID-19 ANSWERS AND ASSISTANCE

Get the latest information about the COVID-19 vaccines, access to testing and treatment, answers to common questions, and coverage details.

Go to bluecrossma.org, and click on **Coronavirus Resource Center under Your Health.**

GET YOUR NO-COST FLU SHOT*

It's recommended that just about everyone 6 months or older should get the flu shot. It's safe and effective, and will help protect you and everyone around you from getting sick, especially young children and the elderly who are the most at risk. Talk to your doctor to see if it's right for you.



Learn more about the flu and where to get your shot at bluecrossma.org/flu.

*Exceptions may apply. Check your plan materials for details.

Here to Make a Difference

We're always working to create a positive experience for our members, and to make our community healthier and more inclusive.



We've been awarded a 100% score on the Disability Equality Index and we've been named a "Best Place to Work for Disability Inclusion" for the second year in a row.



J.D. Power ranked us #1 in member satisfaction among all Commercial Health Plans in Massachusetts, for the 5th year in a row.¹⁰

¹⁰ For J.D. Power 2021 award information, visit jdpower.com/awards.



MASSACHUSETTS

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Programs Enhancing Member Health and Wellbeing

Program Name	Who's Eligible	Description
Good Health Gateway 800.643.8028 MIIA.GoodHealthGateway.com	Available to those on a MIIA/BCBS health plan ages 18 and up.	Diabetes management program to increase care and medication adherence through incentives (\$0 copays for medication/ supplies).
Ompractice ompractice.com/miia	Open to members and non-members of health plan age 13 and up.	Live virtual yoga, meditation, and other mind/body classes.
Learn to Live Learntolive.com/partners Enter access code: miia	Open to members and non-members of health plan age 13 and up.	Online programs and clinical assessments based on the proven principles of Cognitive Behavioral Therapy. Stress, Anxiety & Worry, Depression, Social Anxiety, Insomnia, and Substance Use.
Quizzify App.quizzify.com/users/sign_up/mma	Non-members can play but don't earn prizes.	A monthly Jeopardy-like trivia game that can help participants improve lifestyle, save on health care costs, and differentiate health facts from myths.
Smart Shopper 1-877-281-3722 Log in to bluecrossma.org and click the SmartShopper link.	Available to those on a MIIA/BCBS health plan (not open to every BCBS plan and retirees).	Cashback on non-urgent medical procedures when using preferred providers.

Program Name	Who's Eligible	Description
<p>Ex Program Visit BecomeAnEX.org/signup/MIIA to get started.</p>	<p>Available to those on a MIIA/BCBS health plan.</p>	<p>Digital tobacco/vape cessation program in collaboration with Mayo Clinic that includes nicotine patches/gum delivered to the home. Active online community (peer support), and live-chat coaching from experts.</p>
<p>EAP myassistanceprogram.com/miia-eap/</p>	<p>EAP is open to all employees and their households in MIIA member groups.</p>	<p>In-person and telephonic counseling, training courses, management consultations, critical incident stress debriefing, work/life resources.</p>
<p>Telephonic Wellness Coaching emiia.org/well-aware/wellness-coaching</p>	<p>Available to those on a MIIA/BCBS health plan ages 18 and up.</p>	<p>Up to 10 phone coaching sessions per year with a certified coach. Coaches provide the guidance, accountability and support you need to live a healthier lifestyle. You and your health coach will work together to identify goals and strategies to meet those goals.</p>

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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 CVS Pharmacy[®] retail location, or through the mail service pharmacy.

SWITCHING BRINGS BENEFITS



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



Convenience of filling medications at any of the 9,000+ CVS retail pharmacies.



No additional cost for standard delivery through the mail service pharmacy.



Fewer trips to the pharmacy, or none at all.

EXAMPLE OF HOW YOU CAN SAVE²

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

Questions?

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

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

HOW TO SWITCH TO 90-DAY FILLS



CVS Retail Pharmacy

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

To make sure you receive emails, use MyBlue to update your communication preferences:

- 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** under **Update My Profile**.



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**.



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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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WE SPECIALIZE IN MEDICAL CERTAINTY

Through MIIA Health Benefits Trust, you have an exclusive membership to 2nd.MD, a virtual expert medical consultation and navigation service. We connect you with a board-certified, elite specialist for a virtual expert medical consultation via phone or video from the comfort of home.

2nd.MD specializes in medical certainty by providing access to elite specialists for questions about:

- Diseases, cancer, or chronic conditions
- Surgeries or procedures
- Medications and treatment plans

WHO IS ELIGIBLE?

2nd.MD is confidential, fast and no additional cost to employees and their eligible dependents enrolled in the BCBSMA medical plan.

GET STARTED TODAY

Call at **1.866.841.2575**

Visit **www.2nd.MD/miia**

or download our **2nd.MD app**



Apple, the Apple logo, iPhone, and iPad are trademarks of Apple Inc., registered in the U.S. and other countries and regions. App Store is a service mark of Apple Inc. Google Play and the Google Play logo are trademarks of Google LLC.

CALL 911 IMMEDIATELY IF YOU ARE HAVING A MEDICAL EMERGENCY. 2nd.MD is not an emergency service. 2nd.MD is an independent resource to support you in receiving information from Expert Medical Specialists. 2nd.MD does not practice medicine or provide patient care and is independent from the Specialists providing the expert medical consultations.

HOW IT WORKS: *3 Simple Steps*

- 1. ACTIVATE YOUR ACCOUNT AND REQUEST A CONSULT**
Visit www.2nd.MD/miia, download our app or call us at 1.866.841.2575
- 2. SPEAK WITH A NURSE**
Explain your medical issues and an experienced nurse will handle the rest, including collecting medical records and connecting you with a leading specialist who is an expert in your condition.
- 3. CONSULT WITH A LEADING SPECIALIST**
Get information about your diagnosis, treatment plan and next steps in care from a nationally recognized specialist. Consult via video or phone at a time that works best for you, including evenings and weekends!

AFTER YOUR CONSULTATION

You'll receive a written summary of your consultation so you're prepared for a conversation with your treating doctor.

See how one member avoided an unnecessary surgery and learned how to manage her rare condition.



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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, , 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



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.

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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
- Prosthesis 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.

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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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Meet the MyBlue Member App

Simple, Secure, Convenient

Get Health Care Information Quickly and Easily

The MyBlue Member App gives members instant access to their personal health care information anytime they need it. A simple tap connects them to their doctor, recent prescriptions, and claims history.



Personalized health care, right at their fingertips:



Use the digital ID card to direct-dial important numbers, email a PDF version to a doctor, or save a digital card to their phone.

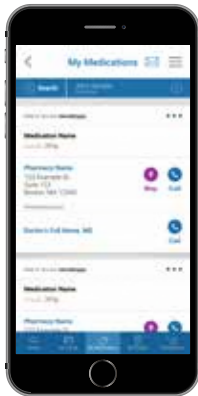


Get access to recent claims history and see copayment amounts.



View financial account balances, like HealthEquity® or Blue Cross

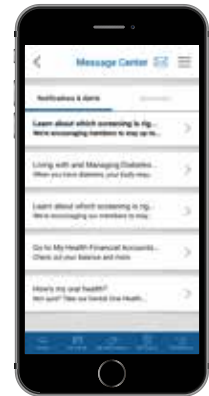
Additional MyBlue Member App features:



See prescription history, including dosage and who prescribed it.



Look up and get directions to nearby doctors, dentists, and hospitals.



Receive push notifications and view important information in the Message Center.

Available On



The MyBlue Member App is not available for members with Federal Employee Program (FEP), Blue Benefit Administrators (BBA), Ancillary (Indigo®), Medicare Advantage or standalone Part D plans. Those with standalone dental, vision, or wellness coverage cannot register for the app at this time.

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1 in 2

people will experience
a mental health issue
during their lifetime.

Feeling stressed, sleepless, anxious or discouraged?
We're here to help.



Access Learn to Live from anywhere!
Mobile app available now for Apple
and Android devices

MIIA has invested in your mental and emotional well-being by offering confidential, online support from Learn to Live at no cost to you.

Learn to Live benefits:

- Immediate, 24/7 access to self-paced programs
- Ability to track progress and success
- No cost to you or your family members (ages 13+)
- As effective as in-person therapy
- Coaching available (phone, email, text)
- English and Spanish programs available

To get started, visit learntolive.com/partners and enter the code: MIIA

 **learntolive** | Stress, Anxiety & Worry, Depression,
Social Anxiety, Insomnia and Substance Use

Our member information is completely confidential, HIPAA compliant and will never be shared with your employer.

© 2022 Learn to Live, Inc. Learn to Live, Inc. is an independent company offering online cognitive behavioral therapy programs and services.

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Earn cash rewards with SmartShopper!

It's so easy to earn cash rewards as your share of the savings when you have one of the 100+ procedures offered by your plan.

Medical procedure costs vary by location.

Use SmartShopper to compare in-network prices for 100+ procedures at high-quality locations. Call or shop online so you can earn cash rewards and save money out-of-pocket with SmartShopper!

Here's how it works



Compare prices and rewards by shopping online or calling the Personal Assistant Team at **1-877-281-3722**.



Schedule your appointment or let the Personal Assistant Team do it for you.



Earn your cash reward by having your appointment within the year.



Visit **bluecrossma.org** or call the SmartShopper Personal Assistant Team at **1-877-281-3722**. The Personal Assistant Team is available to help you shop, find a location, compare costs, confirm rewards and even schedule your appointment. Call today!
Go Green by going paperless! Contact us or scan this code to register your email today.

The Personal Assistant Team is available Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m. ET.



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MIIA Nonprofit
Locally based
Member driven
Serving Massachusetts' communities since 1982

SmartShopper[®]

The SmartShopper program is offered by Sapphire Digital, an independent company. Incentives available for select procedures only. Payments are a taxable form of income. Rewards may be delivered by check or an alternative form of payment. Members with coverage under Medicaid or Medicare are not eligible to receive incentive rewards under the SmartShopper program.

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Some plans and services may require a referral from your doctor. Be sure to check your benefits or call Member Service at the number on the back of your ID card. The money you receive may be considered taxable income. Consult your tax advisor. Members with coverage under Medicaid or Medicare (including as secondary payer) are not eligible to receive incentive rewards under the SmartShopper Program. For HMO Blue New England plans, only network providers located in Massachusetts, Rhode Island, New Hampshire, and Vermont may qualify for rewards under the SmartShopper program. For HMO Blue plans, only network providers located in Massachusetts may qualify for rewards.

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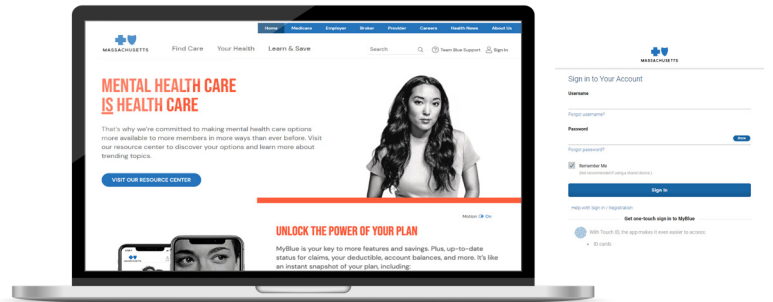
MASSACHUSETTS

GETTING STARTED WITH SMARTSHOPPER[®]

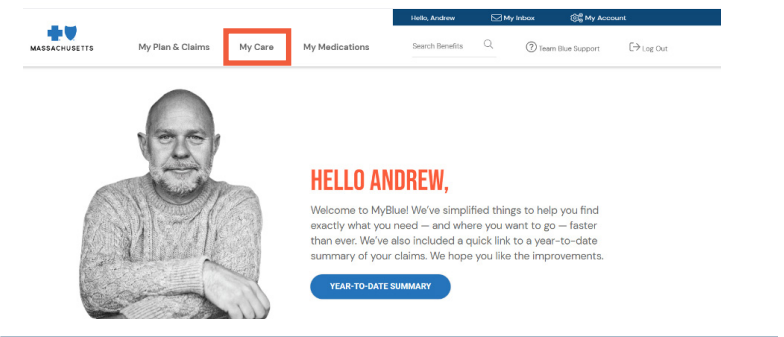
Earning up to \$250 is as easy as 1-2-3.

You can compare competitively priced care, and earn up to \$250 in cash rewards after each eligible procedure when you use SmartShopper from Sapphire Digital[®], an independent company. Getting started is easy. Just follow these three steps:

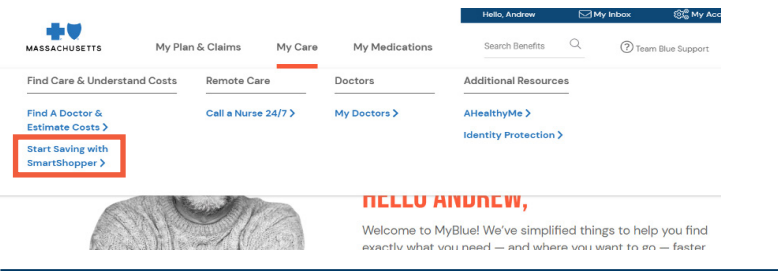
1 Sign in to **MyBlue** or create an account
Visit **bluecrossma.org** to sign in, or click **Create Account** to register for a new one.



2 Go to **My Care**



3 Click **Start Saving with SmartShopper**



Questions?

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



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SmartShopper®

Earn Money with SmartShopper®

SmartShopper is an incentive and engagement program managed by Sapphire Digital®, an independent company. You can earn a reward check each time you or your covered family members choose an eligible lower-cost, quality doctor or facility for the health services below. To find a reward-eligible doctor or hospital, log in to bluecrossma.com/myblue, or call 1-877-281-3722.

Keep this list for future reference.

Save on These Health Care Services	Reward Amount (lowest-cost)	Reward Amount (2nd lowest-cost)	Reward Amount (3rd lowest-cost)
Bladder Repair for Incontinence (sling)	\$250	\$75	\$50
Bladder Scope	\$250	\$75	\$50
Bone Density Scan	\$50	\$25	\$0
Bronchoscopy (procedure to look at airways)	\$150	\$75	\$50
Bunionectomy (bunion surgery)	\$150	\$75	\$50
Carpal Tunnel Treatment	\$150	\$75	\$50
Cataract Removal	\$125	\$75	\$50
Colonoscopy	\$250	\$75	\$50
CT Scan	\$75	\$50	\$0
Hernia Repair	\$150	\$75	\$50
Knee Arthroscopy	\$250	\$75	\$50
Gall Bladder Removal	\$250	\$75	\$50
Laparoscopic Removal of Ovaries and/or Fallopian Tubes	\$250	\$75	\$50
Lithotripsy Fragmenting (shock waves to break apart) of Kidney Stones	\$250	\$75	\$50
Mammogram	\$50	\$25	\$0
MRI	\$100	\$75	\$50
Ear, Nose, Throat (ENT)	\$150	\$75	\$50
PET Scan	\$150	\$75	\$50
Shoulder Arthroscopy	\$250	\$75	\$50
Sigmoidoscopy (procedure to look at rectum and lower colon)	\$150	\$75	\$50
Ultrasounds (non-maternity)	\$50	\$25	\$0
Upper GI Endoscopy	\$150	\$75	\$50

The dollar amount you receive may be considered taxable income. Consult your tax advisor. SmartShopper is managed by Sapphire Digital®, an independent company. Members with coverage under Medicaid or Medicare (including as secondary payer) aren't eligible to receive incentive rewards under the SmartShopper program.

For HMO Blue New England plans, only network providers located in Massachusetts, Rhode Island, New Hampshire, and Vermont may qualify for rewards under the Smart Shopper program. For HMO Blue plans, only network providers located in Massachusetts may qualify for rewards.

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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 **civilrightscordinator@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 Idantifikasyon 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/العربية:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (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 કોલ 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 شماره تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. 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'doowólgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíjijí' béésh bee hodíílnih (TTY: 711).