MASSACHUSETTS

https://planinfo.bluecrossma.com/customblue/2025/miiatownofmiddleton

WELCOME MIIA TOWN OF MIDDLETON

GET THE MOST OUT OF YOUR PLAN

VISIT MYBLUE

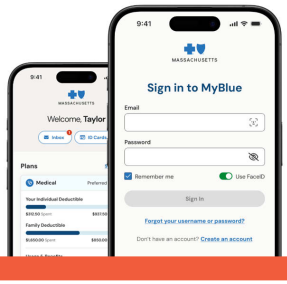
FIND A DOCTOR

LOOK UP A MEDICATION

CONTACT US

SAVINGS AND DEALS

UNDERSTANDING YOUR PLAN AND BENEFITS



INTRODUCING THE NEW MYBLUE APP

The simplest way to tap into your health plan.

Sign in to the MyBlue app.

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BlueCross BlueShield

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

SUMMARY OF BENEFITS

BLUE CARE ELECT PREFERRED

MIIA Town of Middleton

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

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 are 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.

You must pay a calendar-year deductible before you can receive coverage for certain out-of-network benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible is **$250** per member (or **$500** per family).

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 calendar 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). 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.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

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.

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.

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: • Ten 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	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance after deductible
Mental health wellness exams (at least one per calendar year)	Nothing	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing	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	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one per calendar year)	Nothing	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$50 per visit (waived if admitted or for observation stay)	$50 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits	$15 per visit	20% coinsurance after deductible
Mental health or substance use treatment	$15 per visit	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the in-network designated telehealth vendor	 Same as in-person visit $15 per visit	 Same as in-person visit Only applicable in-network
Chiropractors' office visits	$15 per visit	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	$15 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$15 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$15 per visit	20% coinsurance after deductible
Diagnostic x-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance after deductible**
Prosthetic devices	Nothing	20% coinsurance after deductible
Surgery and related anesthesia • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit	 $15 per visit*** Nothing	 20% coinsurance after deductible 20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth, including supplies (20% coinsurance after deductible out-of-network).
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

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)**	$10 for Tier 1 $20 for Tier 2 $35 for Tier 3	Not covered
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	$10 for Tier 1 $20 for Tier 2 $35 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.
** Cost share may be waived, reduced, or increased for certain covered drugs and supplies.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified 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
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness 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?	$0 in-network; $250 member / $500 family out-of-network.	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. Emergency room and emergency transportation.	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?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Specialist visit	$15 / visit; $15 / chiropractor visit; $15 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; cost share waived for at least one mental health wellness exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization 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 or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$20 / retail or mail service supply	Not covered	
	Non-preferred brand drugs	$35 / retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$50 / visit	$50 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; cost share may be waived or reduced for certain services; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first for out-of-network; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Rehabilitation services	$15 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first for out-of-network; limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies first for out-of-network; in-network cost share waived for one breast pump per birth, including supplies (20% coinsurance for out-of-network)
	Hospice services	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam 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% coinsurance for members with a cleft palate / cleft lip condition	Deductible applies first for out-of-network; limited to members under age 18

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam 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	$0
■ Delivery fee copay	$0
■ Facility fee copay	$0
■ Diagnostic tests copay	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$15
■ Primary care visit copay	$15
■ Diagnostic tests copay	$0

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$15
■ Emergency room copay	$50
■ Ambulance services copay	$0

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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

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MCC COMPLIANCE

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

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BlueCross BlueShield

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

SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND $300 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

MIIA Town of Middleton

Plan-Year Deductible: $300/$900

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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

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

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

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

YOUR CARE

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

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**; consult Find a Doctor at **bluecrossma.com/findadoctor**; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school the doctor attended, and whether there are languages other than English spoken in the office.

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

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

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

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

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

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$300** per member (or **$900** 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 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.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

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.

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 are 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.

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
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	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: • 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 $60 per visit, no deductible
Mental health or substance use treatment	$20 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit $20 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	$60 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible
Diagnostic x-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office or health center, when performed by: • 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 $60 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$250 per admission after deductible
Inpatient Care (including maternity care) in:	
• Other general hospitals (as many days as medically necessary) • Higher cost share hospitals (as many days as medically necessary)	$275 per admission after deductible† $1,500 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$275 per admission, no deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	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.
** Cost share waived for one breast pump per birth, including supplies.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible $10 for Tier 1 $30 for Tier 2 $65 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible $25 for Tier 1 $75 for Tier 2 $165 for Tier 3

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

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified 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
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness 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?	$300 member / $900 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, certain mental health services, and therapy visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, $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 cost share may be applicable
	Specialist visit	$60 / visit; $20 / chiropractor visit; $60 / acupuncture visit	Not covered	Limited to 20 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$100	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $25 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$60 / visit	$60 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$275 / admission; $1,500 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	Cost share may be waived or reduced for certain services; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$275 / admission; $1,500 / admission for certain hospitals	Not covered	Deductible applies first for general hospitals; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$275 / admission; $1,500 / admission for certain hospitals	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	Not covered	Deductible applies first except for outpatient services; limited to 30 outpatient visits per type of therapy per calendar year (other than for autism, home health care, and speech therapy); a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$20 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; pre-authorization required for certain services
	Skilled nursing care	20% coinsurance	Not covered	Deductible applies first; limited to 45 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	Not covered	Deductible applies first; cost share waived for one breast pump per birth, including supplies
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	Not covered	Limited to members under age 18

Excluded Services & Other Covered Services:

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

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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 (20 visits per calendar year)
- Hearing aids ($5,000 per ear every 36 months)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- 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**	**$300**
■ **Delivery fee copay**	**$0**
■ **Facility fee copay**	**$275**
■ **Diagnostic tests copay**	**$0**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

■ **The plan's overall deductible**	**$300**
■ **Specialist visit copay**	**$60**
■ **Primary care visit copay**	**$20**
■ **Diagnostic tests copay**	**$0**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

■ **The plan's overall deductible**	**$300**
■ **Specialist visit copay**	**$60**
■ **Emergency room copay**	**$100**
■ **Ambulance services copay**	**$0**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

MASSACHUSETTS

MCC COMPLIANCE

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

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

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BlueCross BlueShield

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

SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND OPTIONS V.5

MIIA Town of Middleton

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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

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

This health plan includes a tiered provider network called HMO Blue New England Options v.5. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **bluecrossma.com/findadoctor** and search for HMO Blue New England Options v.5.

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

Within the HMO Blue New England Options v.5 network, hospitals and groups of primary care providers (PCPs) are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier providers each time you get hospital or PCP care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.

- **Standard Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and are moderate cost relative to our benchmark. This benefit tier includes hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.

- **Basic Benefits Tier**—Includes Massachusetts hospitals that are high cost relative to our benchmark. Also includes primary care providers in Massachusetts who do not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pocket costs when you choose providers in the Basic Benefits Tier.

Note: Primary care providers were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Providers without sufficient data for either cost or quality are placed in the Standard Benefits Tier. Providers that do not meet benchmarks for one or both of the domains and hospitals that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your primary care provider and the facility where your provider has admitting privileges before you choose a PCP or receive care. For example, if you require hospital care and your Enhanced Benefits Tier PCP refers you to an Enhanced Benefits Tier hospital, you would pay the lowest cost sharing for both your PCP and hospital services. Or, if your Enhanced Benefits Tier PCP refers you to a Basic Benefits Tier hospital for care, you will pay the lowest copayments for PCP services, but the highest copayments for hospital services, except in an emergency.

Copayments Outside of Massachusetts and New Hampshire
For network providers outside of Massachusetts and New Hampshire, a network provider who is listed as a general practitioner, internist, family practitioner, pediatrician, obstetrician/gynecologist, nurse practitioner, rural health center, or general hospital is considered an Enhanced Benefits Tier provider. In New Hampshire, a Tier 1 provider equates to an Enhanced Tier Benefits provider and a Tier 2 provider equates to a Standard Tier Benefits provider. Other providers in our New England network carry the higher, specialist copayment.

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 You Can Feel Better About
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 Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for copayments and coinsurance for covered services. If you are not sure when your plan year begins, please contact Blue Cross Blue Shield of Massachusetts. 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). You pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital. Any follow-up care must be arranged by your PCP.

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.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

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.

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 are 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.

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 for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
Preventive Care			
Well-child care exams	Nothing	Nothing	Nothing
Routine adult physical exams, including related tests	Nothing	Nothing	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	Nothing	Nothing
Mental health wellness exams (at least one per calendar year)	Nothing	Nothing	Nothing
Routine hearing exams, including routine tests	Nothing	Nothing	Nothing
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum	All charges beyond the maximum	All charges beyond the maximum
Routine vision exam (one every 24 months)	Nothing	Nothing	Nothing
Family planning services—office visits	Nothing	Nothing	Nothing
Outpatient Care			
Emergency room visits	$100 per visit (waived if admitted or for observation stay)	$100 per visit (waived if admitted or for observation stay)	$100 per visit (waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, nurse midwife, physician assistant, or nurse practitioner (billed by PCP)* • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care • Limited services clinic	 $10 per visit $25 per visit $10 per visit	 $15 per visit $25 per visit $10 per visit	 $20 per visit $25 per visit $10 per visit
Mental health or substance use treatment	$10 per visit	$10 per visit	$10 per visit
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	 Same as in-person visit $10 per visit	 Same as in-person visit $10 per visit	 Same as in-person visit $10 per visit
Chiropractors' office visits (up to 20 visits per calendar year)	$15 per visit	$15 per visit	$15 per visit
Acupuncture visits (up to 12 visits per calendar year)	$25 per visit	$25 per visit	$25 per visit
Short-term rehabilitation therapy—physical and occupational (up to 90 visits per calendar year**)	$15 per visit	$15 per visit	$15 per visit
Speech, hearing, and language disorder treatment—speech therapy	$15 per visit	$15 per visit	$15 per visit
Diagnostic x-rays and lab tests	Nothing	Nothing	Nothing
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date	$100 per category per service date	$100 per category per service date
Home health care and hospice services	Nothing	Nothing	Nothing
Oxygen and equipment for its administration	Nothing	Nothing	Nothing
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing	Nothing	Nothing
Prosthetic devices	20% coinsurance	20% coinsurance	20% coinsurance
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, nurse midwife, physician assistant, or nurse practitioner (billed by PCP)* • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	 $10 per visit*** $25 per visit***	 $15 per visit*** $25 per visit***	 $20 per visit*** $25 per visit***
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission	$150 per admission	$150 per admission
Inpatient Care (and maternity care)			
General hospital care (as many days as medically necessary)	$200 per admission	$400 per admission†	$400 per admission†
Chronic disease hospital care (as many days as medically necessary)	$200 per admission	$200 per admission	$200 per admission
Mental hospital or substance use facility care (as many days as medically necessary)	$200 per admission	$200 per admission	$200 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	Nothing	Nothing
Skilled nursing facility care (up to 45 days per calendar year)	Nothing	Nothing	Nothing

* For services by a physician assistant or nurse practitioner designated as primary care and not billed by the PCP, the Standard Tier PCP office visit cost share will be applied. If these providers are designated by the plan as specialty care, the specialist visit cost share will be applied.

** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
Prescription Drug Benefits*			
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	$10 for Tier 1 $20 for Tier 2 $50 for Tier 3	$10 for Tier 1 $20 for Tier 2 $50 for Tier 3	$10 for Tier 1 $20 for Tier 2 $50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	$20 for Tier 1 $50 for Tier 2 $110 for Tier 3	$20 for Tier 1 $50 for Tier 2 $110 for Tier 3	$20 for Tier 1 $50 for Tier 2 $110 for Tier 3

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

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

Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified 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
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
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.	You pay the least if you use a provider in enhanced benefits tier. You pay more if you use a provider in standard benefits tier or basic benefits tier. 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.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Enhanced Benefits Tier (You will pay the least)	Standard Benefits Tier	Basics Benefits Tier	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	$10 / visit	$15 / visit	$20 / visit	Not covered	A telehealth cost share may be applicable
	Specialist visit	$25 / visit; $15 / chiropractor visit; $25 / acupuncture visit	$25 / visit; $15 / chiropractor visit; $25 / acupuncture visit	$25 / visit; $15 / chiropractor visit; $25 / acupuncture visit	Not covered	Limited to 20 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/ immunization	No charge	No charge	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$100	$100	$100	Not covered	Copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Enhanced Benefits Tier (You will pay the least)	Standard Benefits Tier	Basics Benefits Tier	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $20 / designated retail or mail service supply	$10 / retail supply or $20 / designated retail or mail service supply	$10 / retail supply or $20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$20 / retail supply or $50 / designated retail or mail service supply	$20 / retail supply or $50 / designated retail or mail service supply	$20 / retail supply or $50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$50 / retail supply or $110 / designated retail or mail service supply	$50 / retail supply or $110 / designated retail or mail service supply	$50 / retail supply or $110 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Applicable cost share (generic, preferred, non-preferred)	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	$150 / admission	$150 / admission	Not covered	Pre-authorization required for certain services
	Physician/surgeon fees	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Enhanced Benefits Tier (You will pay the least)	Standard Benefits Tier	Basics Benefits Tier	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	$100 / visit	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	No charge	No charge	None
	Urgent care	$25 / visit	$25 / visit	$25 / visit	$25 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 / admission	$400 / admission	$400 / admission	Not covered	Pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	No charge	No charge	Not covered	Pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 / visit	$10 / visit	$10 / visit	Not covered	Cost share may be waived or reduced for certain services; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$200 / admission	$400 / admission for general hospitals; $200 / admission for mental hospitals or substance abuse facilities	$400 / admission for general hospitals; $200 / admission for mental hospitals or substance abuse facilities	Not covered	Pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	No charge	No charge	Not covered	Cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	No charge	No charge	Not covered	
	Childbirth/delivery facility services	$200 / admission	$400 / admission	$400 / admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Enhanced Benefits Tier (You will pay the least)	Standard Benefits Tier	Basics Benefits Tier	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
	Rehabilitation services	$15 / visit for outpatient services; No charge for inpatient services	$15 / visit for outpatient services; No charge for inpatient services	$15 / visit for outpatient services; No charge for inpatient services	Not covered	Limited to 90 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$15 / visit	$15 / visit	$15 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; pre-authorization required for certain services
	Skilled nursing care	No charge	No charge	No charge	Not covered	Limited to 45 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	No charge	No charge	Not covered	None
	Hospice services	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	No charge for members with a cleft palate / cleft lip condition	No charge for members with a cleft palate / cleft lip condition	Not covered	Limited to members under age 18

Excluded Services & Other Covered Services:

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

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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 (20 visits per calendar year)
- Hearing aids ($5,000 per ear every 36 months)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- 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**	**$0**
■ **Delivery fee copay**	**$0**
■ **Facility fee copay**	**$400**
■ **Diagnostic tests copay**	**$0**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$460**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist visit copay**	**$25**
■ **Primary care visit copay**	**$15**
■ **Diagnostic tests copay**	**$0**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

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

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

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

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

MASSACHUSETTS

MCC COMPLIANCE

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

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MASSACHUSETTS

This health plan includes a tiered provider network called HMO Blue New England Options v.5. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **bluecrossma.com/findadoctor** and search for HMO Blue New England Options v.5.

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

SUMMARY OF BENEFITS

NETWORK BLUE® SELECT $300 DEDUCTIBLE

MIIA Town of Middleton

Plan-Year Deductible: $300/$900

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 certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$300** per member (or **$900** 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 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.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

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.

Service Area
The plan's service area includes all Massachusetts counties except Dukes, Barnstable, and Nantucket.

When Outside the Service Area
If you are 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.

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
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	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: • 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 $60 per visit, no deductible
Mental health or substance use treatment	$20 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit $20 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	$60 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office or health center, when performed by: • 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 $60 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$250 per admission after deductible
Inpatient Care (including maternity care)	
General hospital care (as many days as medically necessary)	$275 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$275 per admission, no deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	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.
** Cost share waived for one breast pump per birth, including supplies.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible $10 for Tier 1 $30 for Tier 2 $65 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible $25 for Tier 1 $75 for Tier 2 $165 for Tier 3

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

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified 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
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness 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?	$300 member / $900 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, certain mental health services, therapy visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, $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 cost share may be applicable
	Specialist visit	$60 / visit; $20 / chiropractor visit; $60 / acupuncture visit	Not covered	Limited to 20 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$100	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $25 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$60 / visit	$60 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$275 / admission	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	Cost share may be waived or reduced for certain services; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$275 / admission	Not covered	Deductible applies first for general hospitals; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$275 / 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	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	Not covered	Deductible applies first except for outpatient services; limited to 30 outpatient visits per type of therapy per calendar year (other than for autism, home health care, and speech therapy); a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$20 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; pre-authorization required for certain services
	Skilled nursing care	20% coinsurance	Not covered	Deductible applies first; limited to 45 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	Not covered	Deductible applies first; cost share waived for one breast pump per birth, including supplies
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	Not covered	Limited to members under age 18

Excluded Services & Other Covered Services:

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

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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 (20 visits per calendar year)
- Hearing aids ($5,000 per ear every 36 months)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- 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	$300
■ Delivery fee copay	$0
■ Facility fee copay	$275
■ Diagnostic tests copay	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

■ The plan's overall deductible	$300
■ Specialist visit copay	$60
■ Primary care visit copay	$20
■ Diagnostic tests copay	$0

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

■ The plan's overall deductible	$300
■ Specialist visit copay	$60
■ Emergency room copay	$100
■ Ambulance services copay	$0

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

MASSACHUSETTS

MCC COMPLIANCE

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

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MASSACHUSETTS

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.

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MASSACHUSETTS

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

SUMMARY OF BENEFITS

DENTAL BLUE® FREEDOM

(WITH ORTHODONTICS)

MIIA Town of Middleton

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

For members under age 13, benefits (except for orthodontic services) are covered in full up to the calendar-year benefit maximum and are not subject to the deductible.

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)		

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

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

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

Oral Surgery
- Tooth extraction
- Root removal
- Biopsies

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

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

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

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

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

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

Implants (members age 16 or older)
- 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
- 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 participating dentists in Massachusetts and nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

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

Your 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. **For members under age 13, these benefits (not including orthodontic services) are covered in full up until the calendar-year benefit maximum.** 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.

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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

Save on vision care with Blue 20/20 PLUS when you use a PLUS Provider

BLUE 20/20 PLUS EXAM-PLUS VISION PLAN: ACCESS NETWORK

$130 Frame, $25 Lens, 24/12/24 Frequency[1]

Vision care service	In-network member cost at PLUS providers	In-network member cost	Out-of-network reimbursement[2]
Comprehensive eye exam	**$0 copay**	$20 copay	up to $50
Contact lens fit and follow-up[3]			
• Standard	up to $55	up to $55	n/a
• Premium	10% off retail price	10% off retail price	n/a
Retinal imaging	up to $39	up to $39	n/a
Enhanced Diabetes Eye Care Benefit[4] For members diagnosed with type 1 or type 2 diabetes	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	n/a
Frames	**$180 allowance, then additional 20% off the balance**	$130 allowance, then additional 20% off the balance	up to $74
Standard plastic lenses			
• Single vision	$25 copay	$25 copay	up to $42
• Bifocal	$25 copay	$25 copay	up to $78
• Trifocal	$25 copay	$25 copay	up to $130
• Lenticular	$25 copay	$25 copay	up to $130
• Standard progressive lens	$90 copay	$90 copay	up to $140
• Premium progressive lens	$90 copay, then 80% of charge less $120 allowance	$90 copay, then 80% of charge less $120 allowance	up to $196
Lens options[3]			
• UV treatment	$15	$15	n/a
• Tint (solid and gradient)	$15	$15	n/a
• Standard plastic scratch coating	$15	$15	n/a
• Standard polycarbonate	$40	$40	n/a
• Standard polycarbonate for covered dependents under age 19	Paid in full	Paid in full	up to $26
• Standard anti-reflective coating	$45	$45	n/a
• Photochromic/Transitions®✓ plastic	20% off retail price	20% off retail price	n/a
• Polarized	20% off retail price	20% off retail price	n/a
• Other add-ons	20% off retail price	20% off retail price	n/a
Contact lenses[5]			
• Conventional	$130 allowance, then additional 15% off the balance	$130 allowance, then additional 15% off the balance	up to $104
• Disposable	$130 allowance	$130 allowance	up to $104
• Medically necessary	Paid in full	Paid in full	up to $210
Frequency			
• Exam		once every 24 months	
• Lenses for frames or one order of contact lenses		once every 12 months	
• Frames		once every 24 months	

1. For costs and further details about the coverage, including exclusions, refer to your plan materials. 2. Your actual expenses for covered services may exceed the stated out-of-network amount.
3. Indicates a service that is a discounted arrangement as part of your vision plan. 4. Consult with your vision care provider. 5. 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 VISION

TARGET OPTICAL™

and many regional retailers.

ONLINE SHOPPING OPTIONS

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

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

SAVE ON HEARING EXAMS AND HEARING AIDS

You can save on services and products from Amplifon Hearing, an independent company.

To learn more, visit **amplifonusa.com/blue2020**. To get started, call **1-866-921-5367**.

Blue 20/20 is administered by EyeMed Vision Care®, an independent vision benefits company.

Questions?

Call Blue 20/20 Customer Service at **1-855-875-6948**.
To locate an in-network provider, create an account at **blue2020ma.com**.

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HMO BLUE NEW ENGLAND OPTIONS V.5 HOSPITAL TIERING

Presented below are the HMO Blue New England Options v.5 tiering levels for hospitals in New Hampshire.

HOSPITAL TIERING LEVELS

New Hampshire primary care providers and hospitals will now be placed into one of two benefit tiers. Member costs for some doctors and hospitals in New Hampshire will change, depending on the new tier a doctor or hospital is assigned. A network primary care provider or network general hospital located in NH will now be considered either:

TIER 1 (ENHANCED BENEFITS TIER)

Includes New Hampshire hospitals and Primary Care Providers (PCPs) that meet the standards for quality and low cost relative to our benchmark.

TIER 2 (STANDARD BENEFITS TIER)

Includes New Hampshire hospitals and PCPs that meet the standards for quality and are moderate cost relative to our benchmark and hospitals that don't meet the standards for quality but are low or moderate cost relative to our benchmark. Also includes providers without sufficient data for measurement on one or both benchmarks.

There will be no NH providers equivalent to the Basic Benefits Tier.

Questions?

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

This document gives general information about our tiered network plan designs. There are currently three tiered provider networks called HMO Blue New England Options v.5 and Preferred Blue® PPO Options v.5. In our tiered plans, members pay different levels of cost share (copayments, co-insurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **member.bluecrossma.com/fad** and search for the appropriate network.

HOSPITAL LIST

HOSPITAL NAME	CITY	STATE	NEW HAMPSHIRE TIER	EQUIVALENT MASSACHUSETTS TIER
Alice Peck Day Memorial Hospital	Lebanon	NH	Tier 1	Enhanced Benefits Tier
Androscoggin Valley Hospital	Berlin	NH	Tier 2	Standard Benefits Tier
Catholic Medical Center	Manchester	NH	Tier 2	Standard Benefits Tier
Cheshire Medical Center	Keene	NH	Tier 1	Enhanced Benefits Tier
Concord Hospital	Concord	NH	Tier 2	Standard Benefits Tier
Cottage Hospital	Woodsville	NH	Tier 1	Enhanced Benefits Tier
Dartmouth-Hitchcock Medical Center	Lebanon	NH	Tier 2	Standard Benefits Tier
Elliot Hospital	Manchester	NH	Tier 1	Enhanced Benefits Tier
Exeter Hospital	Exeter	NH	Tier 2	Standard Benefits Tier
Franklin Regional Hospital	Franklin	NH	Tier 2	Standard Benefits Tier
Frisbie Memorial Hospital	Rochester	NH	Tier 1	Enhanced Benefits Tier
Huggins Hospital	Wolfeboro	NH	Tier 2	Standard Benefits Tier
Lakes Region General Hospital	Laconia	NH	Tier 2	Standard Benefits Tier
Littleton Regional Hospital	Littleton	NH	Tier 2	Standard Benefits Tier
Memorial Hospital	North Conway	NH	Tier 1	Enhanced Benefits Tier
Monadnock Community Hospital	Peterborough	NH	Tier 1	Enhanced Benefits Tier
New London Hospital	New London	NH	Tier 2	Standard Benefits Tier
Parkland Medical Center	Derry	NH	Tier 1	Enhanced Benefits Tier
Portsmouth Regional Hospital	Portsmouth	NH	Tier 1	Enhanced Benefits Tier
Southern NH Medical Center	Nashua	NH	Tier 1	Enhanced Benefits Tier
Speare Memorial Hospital	Plymouth	NH	Tier 1	Enhanced Benefits Tier
Upper CT Valley Hospital	Colebrook	NH	Tier 2	Standard Benefits Tier
Valley Regional Hospital	Claremont	NH	Tier 2	Standard Benefits Tier
Weeks Medical Center	Lancaster	NH	Tier 2	Standard Benefits Tier
Wentworth-Douglass Hospital	Dover	NH	Tier 1	Enhanced Benefits Tier

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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

HOSPITAL CHOICE COST SHARING

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

LOWER COST SHARE

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

HIGHER COST SHARE

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

HOW HOSPITAL CHOICE COST SHARING WORKS

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

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

Questions?

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

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

FOLLOW THESE THREE SIMPLE STEPS

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

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

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

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

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

Step 3: Choose Hospitals with a Lower Cost Share

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

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

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

HOSPITAL LIST

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

Continued

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

Continued

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

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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**).
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DOCTORS ON CALL, ON YOUR DEVICE.

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

REAL DOCTORS. REAL EXPERIENCE. REALLY FAST.

GET MEDICAL CARE 24/7

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

THERAPY THAT COMES TO YOU

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

HIGHLY EXPERIENCED, HIGHLY RATED

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

Sign In

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

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

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

IS A VIDEO DOCTOR VISIT RIGHT FOR ME?

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

"I'm not feeling well."

Get care for:

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

"I need emotional support."

Talk to a therapist about:

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

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

"My loved one is under the weather."

If they're on your plan:

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

WELL CONNECTION IS HIGHLY RATED:

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

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

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

4. Prescription availability is defined by doctor judgment.

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

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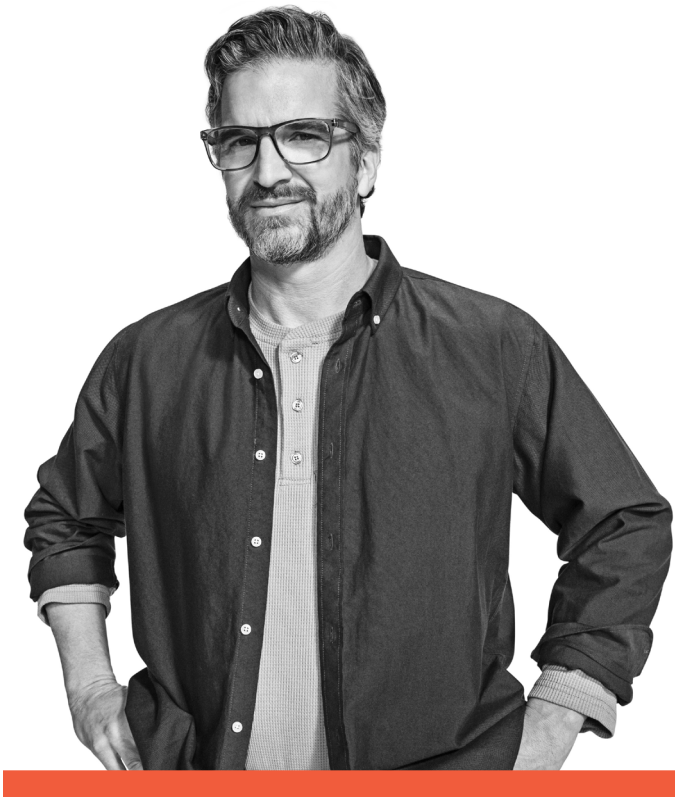
MASSACHUSETTS

SAVE TIME AND MONEY WITH MAINTENANCE CHOICE VOLUNTARY

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



SWITCHING BRINGS BENEFITS

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

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

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

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

EXAMPLE OF HOW YOU CAN SAVE[3]

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

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

(Continued)

HOW TO SWITCH TO 90-DAY FILLS

Participating retail pharmacy

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

To find a participating pharmacy:

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

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

Mail service pharmacy

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

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

STAY CONNECTED

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

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

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

3 Go to **Profile**.

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

Questions?

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

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SAVING SHOULD ALWAYS BE THIS EASY

You shouldn't have to go out of your way to save money on medications. The Cost-Share Assistance Program provides financial assistance, using coupons from manufacturers of medication, to cover most or all of your out-of-pocket costs for eligible medications that you or your dependent may be taking. You don't have to change anything about your prescriptions to get these savings. You just need to be enrolled in the program.

HOW DO I OR MY DEPENDENT BECOME ENROLLED IN THE COST-SHARE ASSISTANCE PROGRAM?

There are two ways to be enrolled:

1. If you were already using coupons to help cover your costs for medications that you were taking before your plan year began, **you've been automatically enrolled in the program**. PillarRx Consulting, an independent company that administers the program, will call you to confirm your enrollment.

2. If you're not using coupons for an eligible medication at the beginning of your plan year, or you or your dependent start taking an eligible medication during the plan year, PillarRx will call you to discuss the program and help you enroll.

HOW THE PROGRAM WORKS

Fill your prescription

When you fill an eligible medication, a manufacturer's coupon will be automatically applied at checkout.

Enjoy instant savings

You'll pay $0 to $35, depending on the medication.

Get personalized, ongoing support

PillarRx checks your claims every month to make sure you're receiving the correct savings, and provides additional support as needed.

Your medication costs will be higher if you or your dependent isn't enrolled.

Enrollment in the Cost-Share Assistance Program is optional. However, **if you don't enroll in the program or decide to opt out of it, you'll be responsible for paying 30% of the full retail cost of eligible medications**.

Questions?

If you have any questions, call a PillarRx Care Team Coordinator at **1-636-614-3128** (TTY: **711**), Monday through Friday, 8:00 a.m. to 7:00 p.m. ET.

(Continued)

What is a manufacturer's coupon?

A manufacturer's coupon (also known as a copay card, copay coupon, copay assistance card, or manufacturer financial assistance) is part of the copay savings programs offered by manufacturers of medication to members with commercial health insurance.

How do I enroll myself or my dependent in the program?

If you or your dependent is taking an eligible medication, and you're not using a coupon to cover your costs, a Care Team Coordinator from PillarRx will call to talk to you about the program and walk you through the enrollment process. They'll also call you if you or your dependent start taking a new eligible medication. You can also call PillarRx directly at **1-636-614-3128** (TTY: **711**).

Do I need to enroll if I'm already using a manufacturer's coupon for an eligible medication?

No. If you're already using a manufacturer's coupon, **you'll be automatically enrolled in the program**. A Care Team Coordinator from PillarRx will call you to confirm your participation. They'll also ensure that you're paying the lowest possible cost for your medication. You can also call PillarRx directly at **1-636-614-3128** (TTY: **711**).

Am I required to be enrolled in the program?

No, enrollment is optional. However, **if you don't enroll yourself or your dependent in the program, or decide to opt out after being enrolled, your out-of-pocket costs for your medications will be higher because you'll be responsible for paying 30% of the cost of the eligible medications.**

What if I filled my eligible medication before I enrolled in the program?

If you've already filled an eligible medication and you're eligible for the program, call PillarRx at **1-636-614-3128** (TTY: **711**) to learn more about retroactive enrollment.

How does the program affect my out-of-pocket maximum?

Once you or your dependent is enrolled in the Cost-Share Assistance Program, your plan will apply only your *actual* out-of-pocket costs to your annual out-of-pocket maximum. For example, if you pay $10 for an eligible medication, only $10 will be applied to your annual out-of-pocket maximum.

How does the program affect my deductible?

If you have a Health Savings Account (HSA)-qualified "Saver" plan, or a plan with a deductible that applies to your pharmacy benefits, your plan will apply your out-of-pocket costs to your annual deductible as well as to your out-of-pocket maximum.[1] For example, if you pay $10 for an eligible medication, only $10 will be applied to both your out-of-pocket maximum and your deductible.

What happens if the manufacturer no longer offers financial assistance for my medication?

PillarRx will notify you that your medication is no longer eligible for this program. You'll then pay the standard cost share for this medication according to your pharmacy benefit. Check your Summary of Benefits or Schedule of Benefits for details.

Are there instances where I may not be able to sign up for the program?

Although most members can enroll, there may be specific instances that make you ineligible for the program, such as:

- You have or are eligible for government health insurance, such as Medicare or Medicaid.
- Your medication isn't approved by the Food and Drug Administration (FDA) to treat your condition.
- Your medication has specific age restrictions you don't meet.
- You use a secondary insurer in addition to Blue Cross to cover your plan's out-of-pocket costs.

If a manufacturer of medication determines that you're ineligible for the program, PillarRx's Care Team will ensure that your medication is covered, based on the standard cost-share amount that applies for all other covered medications and supplies as described in your Summary of Benefits, Schedule of Benefits, and/or riders. In this instance, you wouldn't be eligible for cost savings for your medication through this program.

See if your medication is eligible

To see a list of eligible medications:

1. Download the MyBlue app, or create an account at **bluecrossma.org**.
2. Once signed in, click **Cost-Share Assistance** under **My Medications**.
3. Select **See Eligible Medications**.

You can also call PillarRx Care at **1-636-614-3128** (TTY: **711**), Monday through Friday, 8:00 a.m. to 7:00 p.m. ET.

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

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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

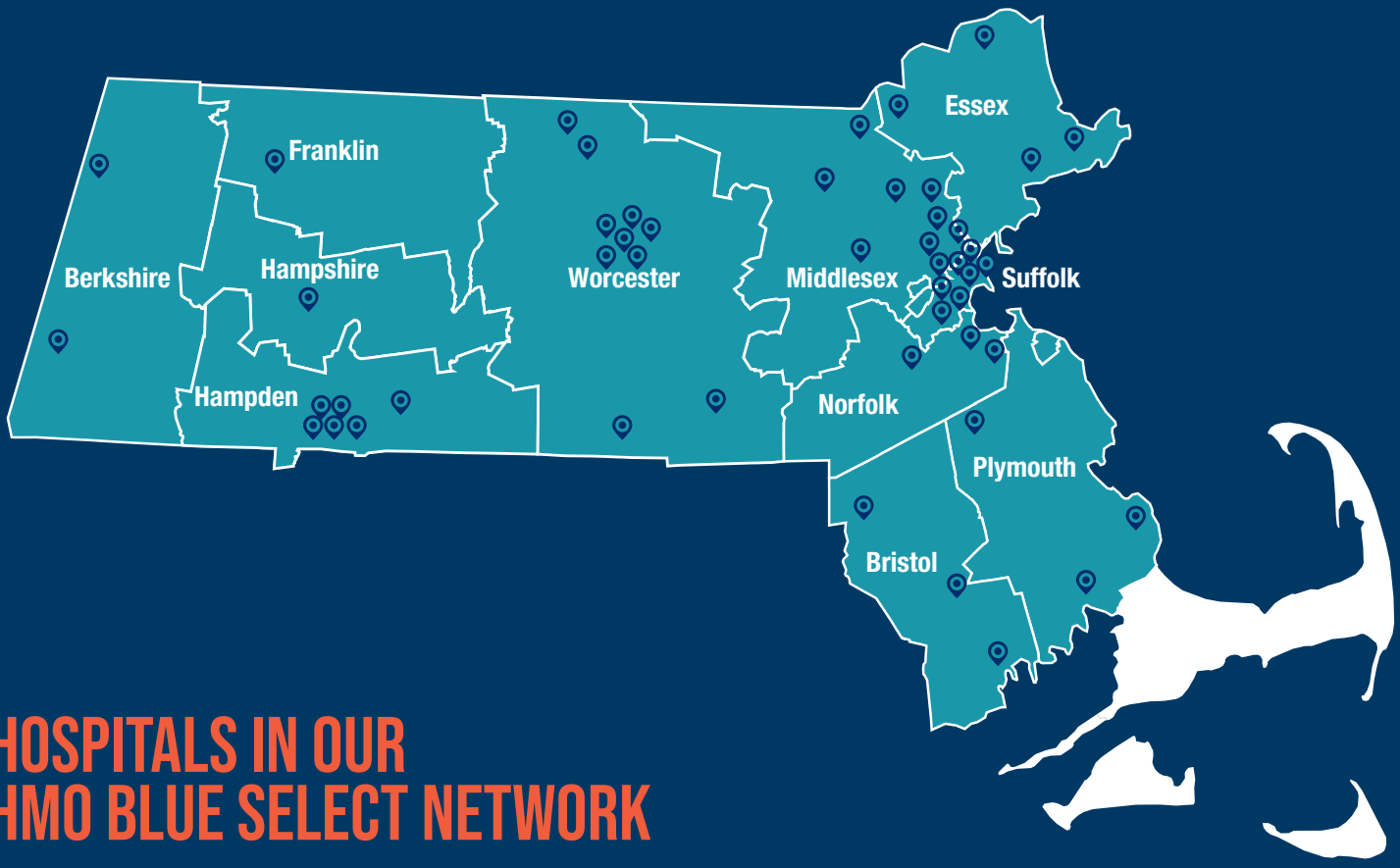
Getting the most value out of your plan is simple—your employees get care at lower-cost providers in the HMO Blue Select network. The savings will be reflected in lower health care costs for you.

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

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

GET YOUR NO-COST FLU SHOT

The flu shot is quick and easy, and will help protect you and everyone around you this flu season. The flu shot reduces your risk of catching the flu and eases your symptoms if you become sick.[1] Get your flu shot today at a convenient location near you.

WHERE TO GET YOUR SHOT

The flu shot is available at no additional cost[2] from in-network providers and locations, like a primary care provider or pharmacy. To find an in-network provider or location near you, go to **bluecrossma.com/findadoctor**.

LEARN MORE

Just about everyone six months and older should get the annual flu shot.[1] Learn more about the flu and the flu shot at **bluecrossma.org/flu**.

1. CDC, "Seasonal Flu Vaccines," https://www.cdc.gov/flu/prevent/flushot.htm.
2. Flu vaccines recommended by the CDC are covered in full when administered by an in-network provider. Exceptions may apply. Check plan materials for details.

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MASSACHUSETTS

GETTING MORE. NOW THERE'S A PLAN.

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

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

UNLOCK THE POWER OF YOUR PLAN

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

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

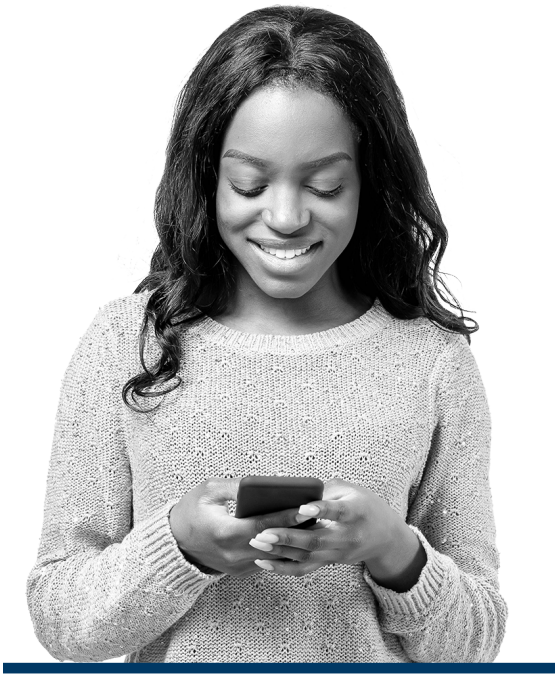
Get the App

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

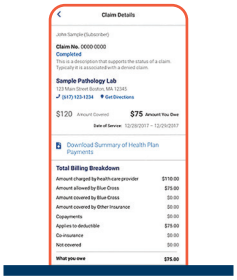
STAY ON TOP OF YOUR COVERAGE

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

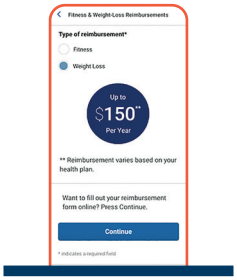
YOUR PLAN IN YOUR HAND



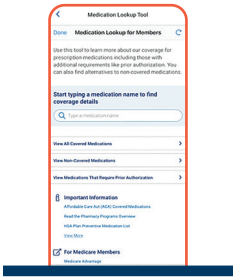
Once you sign in or create a MyBlue App account, you can see all of your benefits, all in one place.
Track your claims, medications, account balances, and more from your device. And, you can easily keep track of reimbursements and savings.



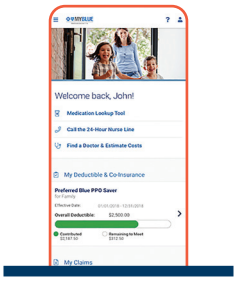
Track claims and benefits
Keep up to date on benefits and coverage.



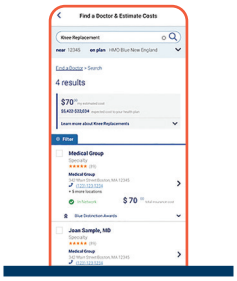
Fitness and weight-loss reimbursement
The online forms are here, along with other savings and offers.



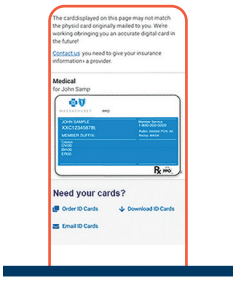
Your medications at a glance
Their names, costs, and prescriptions at your fingertips.



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



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



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

GET THE MYBLUE APP

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

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2nd.MD
Specializing in Medical Certainty

MIIA
Nonprofit
Locally based
Member driven
Serving Massachusetts communities since 1982

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

Download on the App Store | GET IT ON Google Play

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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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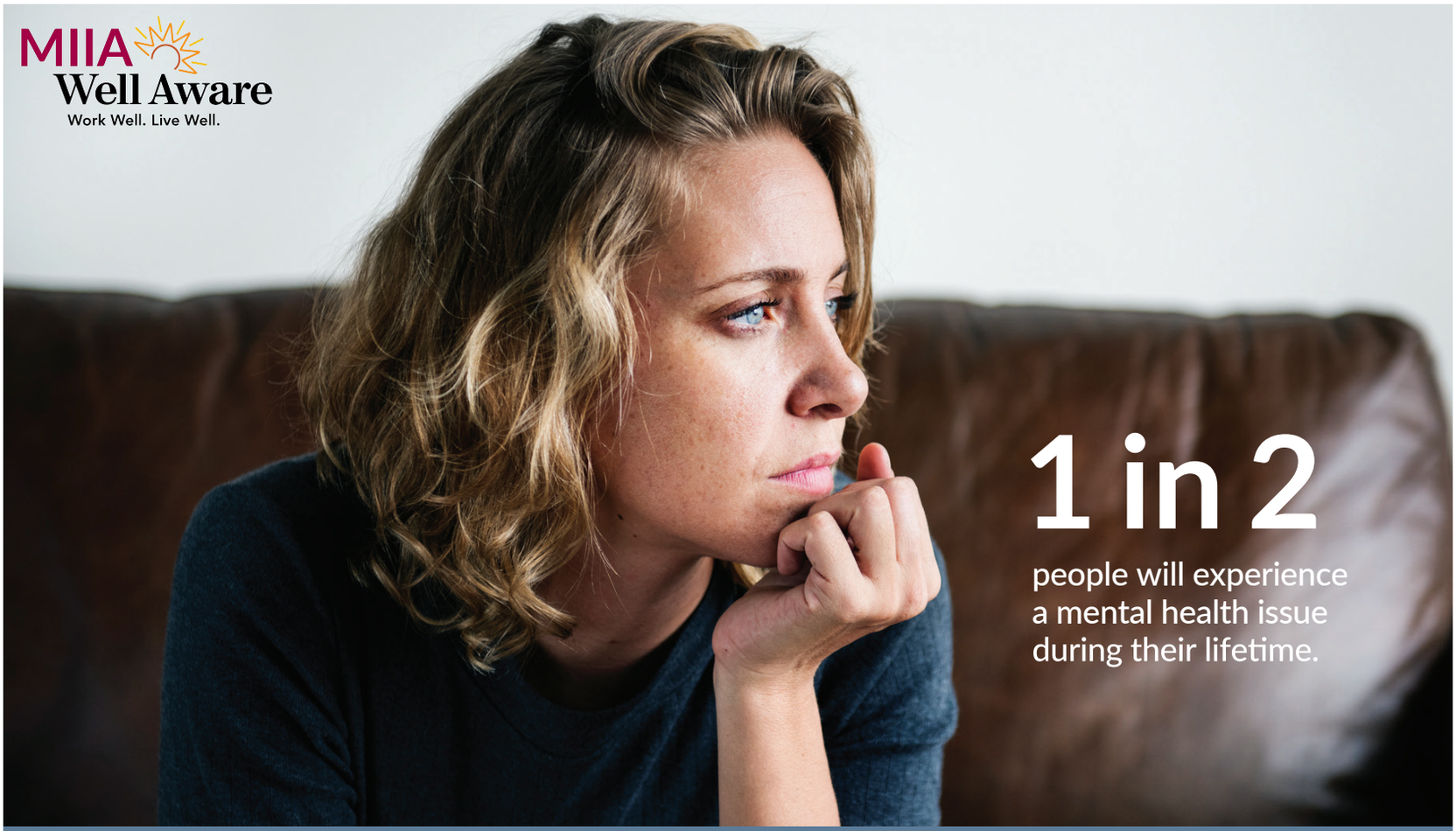
MIIA Well Aware
Work Well. Live Well.



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.

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MASSACHUSETTS

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

A WHOLE NEW WAY TO DO PRIMARY CARE

Your Virtual Care Team is coming

If you've been looking for primary care that's convenient, thorough, engaging, and modern, we're on it. Starting next year, you can choose a virtual primary care provider (PCP) to lead your new Virtual Care Team.

PRIMARY CARE THAT'S A PRIME EXPERIENCE

It's a new kind of primary care — one that comes with a team of experts committed to getting you the care you need.

CONVENIENT

With virtual visits, there's no need to travel to the doctor's office and no waiting room.

COMPREHENSIVE

Your team is here to make sure your physical and mental health needs are met.

COORDINATED

If you need in-person care, a care coordinator will help find in-network specialists who work for you.

SIGN UP TODAY!

Log into your MyBlue account to get started.

Coverage details may vary. Please check your 2023 plan benefits for more information.

HERE'S HOW IT WORKS

START BY PICKING YOUR VIRTUAL PCP + **ENJOY MORE CONVENIENT CARE** + **GET THE BEST OF BOTH WORLDS**

To get started with your Virtual Care Team, the first step is selecting a virtual PCP. You'll also get access to a care coordinator, and your team may include other experts, such as a mental health specialist, picked based on your health needs. It's the care you need most, in the most convenient way.

Scheduling visits is as easy as hopping online, with appointments available in days, and you can get them within days, not weeks. Plus, you can reach out to your team with questions via talk, text, email, and chat. It's care that works on your terms, on your schedule, wherever you are, with a level of communication, technology, and access that will surprise you.

After your first visit, you'll receive a welcome kit which may include connected medical devices, like a blood pressure monitor, that make your virtual care as thorough as in-person sessions. When you do need in-person care, your team will help find a specialist who works for you and follow up with you after the appointment.

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MASSACHUSETTS

SUPPORT FOR YOUR MATERNITY JOURNEY

It has never been more important to make sure you're getting every benefit available to you, throughout your pregnancy and your baby's first year. If you have any questions, we're here to help with a full range of maternity programs and benefits you can explore as your family grows.

Maternity Care Management

You don't have to go it alone. Our Care Managers offer specialized pregnancy and postpartum support to help you improve your health and avoid complications. To work with a Care Manger one-on-one, call **1-800-392-0098** Monday through Friday, 8:30 a.m. to 4:30 p.m. ET.

Lactation Consultations

Our network includes board-certified Lactation Consultants who work with parents and infants to address any breastfeeding challenges, and support breastfeeding for as long as you choose. To see a list of participating lactation consultants, go to **bcbsma.info/lactationcounseling**.

24/7 Nurse Line

If you have questions about your newborn, yourself, or need other medical advice, connect directly to a nurse 24/7. Get immediate advice—no waiting for a callback. Call **1-888-247-BLUE (2583)**.

Breast Pump Savings

Easily compare pump features to find the one that's right for you. Many are available at no cost and can be delivered right to your door. 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. Learn more at **bcbsma.info/childbirthcourse**.

Maternal Mental Health Support

It's normal for new and expectant mothers to experience mental health struggles. If you have symptoms of anxiety, depression, or other mental health issues, our Maternity Mental Health program provides support, education, and treatment referrals. To speak with a Mental Health Care Manager, call **1-800-524-4010**, ext. **62398**, Monday through Friday, 8:30 a.m. to 4:30 p.m. ET.

Learn More

To see all your maternity benefits in one place, visit **bluecrossma.org/maternity**.

MYBLUE IS HERE TO HELP

MyBlue gives you instant access to your plan benefits, all in one place. Find an in-network provider, see mental health options, check the status of a claim, and more.

To sign in or create an account, go to **bcbsma.info/signin3**, or scan the QR code with your smartphone's camera.

MASSACHUSETTS

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

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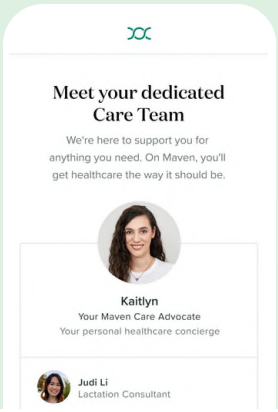
MAVEN | MIIA Nonprofit Locally based Member driven Serving Massachusetts communities since 1982

Meet Maven. Free virtual support for family building, pregnancy, parenting, and menopause.

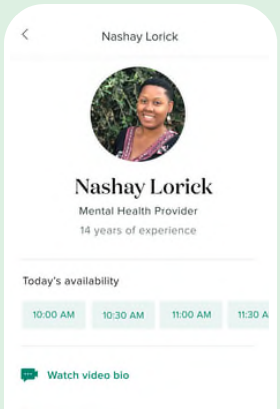
With Maven, you get personalized 24/7 guidance for your path to parenthood and beyond—when you need it, how you need it (yep, even at 2am).

Here's what you and your partner get with Maven:

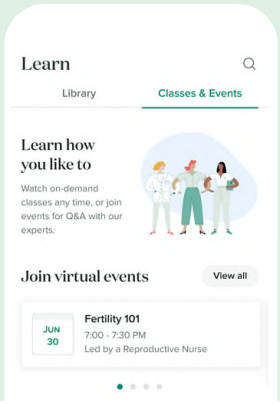
24/7 personalized support from a dedicated Care Advocate



Virtual appointments and messaging with specialists—anytime day or night



On-demand classes, groups, and articles for expert guidance you can trust



At Maven, we're with you every step of the way

From starting a family

- Thinking about planning your family
- Exploring fertility treatments (IUI, IVF and egg freezing)
- Choosing a surrogacy or adoption agency
- Managing your mental health

to having a child

- Creating your birth plan
- Breastfeeding or bottle feeding support
- Navigating infant sleep
- Returning to work

to navigating parenthood

- Pediatric care
- Parent coaching
- Help finding the right childcare
- Developmental support

to managing all stages of menopause

- Managing symptoms
- Understanding treatment options
- Pelvic floor therapy
- Career coaching

The best part? MIIA fully covers your Maven membership. This means no co-pays and no out-of-pocket costs for Maven appointments and resources. Seriously, no strings attached.

Scan the QR code to get started or go to mavenclinic.com/join/MIIA or download the Maven Clinic app.

Maven is free to MIIA/Blue Cross Blue Shield subscribers and their partners/spouses on an active plan.

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MASSACHUSETTS

DENTAL BLUE®
ENHANCED DENTAL BENEFITS

Additional Support for Members with Qualifying Conditions

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

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

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

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

(Continued)

USING THESE BENEFITS

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

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

Accessing Enhanced Dental Benefits

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

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

4. Qualifying members only.

Questions?

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

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ENHANCED DENTAL BENEFITS ENROLLMENT FORM

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

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

Please check qualifying medical conditions:

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

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

Subscriber/Member Information

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

To Be Completed By Your Doctor

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

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

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

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

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BLUE 20/20

LITTLE EYES, BIG BENEFITS

Vision coverage for kids under 19

Eye care is so important for kids — detecting and correcting changes in vision early on can have a lasting impact and even improve learning outcomes. That's why Blue 20/20 will provide vision coverage for kids under 19 at no additional cost to you starting July 1, 2024.* We're committed to keeping an eye on the overall health of your dependents with the enhanced vision coverage they need to thrive.

Services	Coverage
Two fully covered eye exams at $0 copay per benefit frequency	✓
One pair of replacement lenses subject to prescription change per benefit frequency	✓
Fully covered blue-light prescription lenses treatment	✓
Fully covered standard polycarbonate lenses	✓

*We partner with EyeMed® Vision Care, an independent vision benefits company, to offer our comprehensive vision plans.

SAVINGS AND DISCOUNTS

40% off
replacement glasses from in-network locations

25% off
non-prescription blue-light glasses

20% off
sports-related eyewear and non-prescription sunglasses

WHAT YOU NEED TO KNOW

Benefits will be applied to your plan automatically

Applies to in-network vision providers

At no additional cost to you

Learn more

To see plan details and discount information, visit **blue2020ma.com**.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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

YOUR URGENT CARE OPTIONS

24/7 NURSE LINE

Speak directly to a registered nurse 24/7, at no additional cost. Get immediate advice — no waiting for a call back. Call 1-888-247-BLUE (2583).

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

Cost:
Time:
Severity:

WELL CONNECTION

Get convenient medical care from licensed professionals, 24/7, using your favorite device. Sign in to the MyBlue app or visit bluecrossma.org, and click Well Connection.

Best for: cold and flu symptoms, fever, sore throat, rash, and other minor issues.

Cost:*
Time:
Severity:

DOCTOR'S OFFICE

Call your doctor for urgent health concerns that occur during office hours.

Best for: questions about when to seek care and advice for minor issues.

Cost:
Time:
Severity:

LIMITED SERVICE CLINICS

For simple medical concerns you can visit a limited service clinic, found in local pharmacies.

Best for: cold and flu, bronchitis, sinus and respiratory infections, sore throat, diarrhea, and similar, less severe issues.

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, respiratory issues, bites, cuts, concussion screening, stitches, asthma attack, and other somewhat severe issues.

Cost:
Time:
Severity:

EMERGENCY ROOM

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

Best for: difficulty breathing, chest pain or upper abdominal pain or pressure, seizures, swelling or hives, severe burns, sudden blurred vision, fainting, sudden dizziness, persistent vomiting or diarrhea, and suddenly being unable to speak, see, walk, move, or comprehend.

Cost:
Time:
Severity:

The information in this document doesn't replace the advice of a health care provider. You should speak to your provider about any specific health concerns.

1. Telehealth copays are waived for in-network visits, excluding those on the Saver Plan who have not yet met the annual deductible.
2. 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 in the United States only.

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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
- Athletic shoes - Shoes designed to be worn for sports, exercising, or recreational activity. Categories: running/training/walking, court sports, field sports, outdoor sports, track and field, and specialty shoes (i.e., gymnastics, weightlifting, etc.)
- Sports/Activity Fees - Ski passes, adult/child league sports fees (including town sports, tennis, etc.), race participation fees (5K, marathons, etc.)
- Bicycles/Bicycle Helmets- recreational bicycles and bicycle helmets

Not Qualified for Reimbursement:

- One-time initiation or termination fees
- Personal trainer sessions
- Casual and Dress Footwear

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):

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

Name, Address, and Phone Number of Qualified Fitness Expense

Total Dollars requested for Qualified Fitness Expense: $ _____

Calendar year that fees were paid: _____

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

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

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

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

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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) q Male q Female	Date of Birth ___/___/____

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

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

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

Total dollars requested: $ _____

Monthly program participation fee: $ _____

Calendar Year: ___/___/____

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

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

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

Important Information:

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

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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MIND AND BODY REIMBURSEMENT

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

Save up to

$300

per family per calendar year.

Qualified for Mind and Body Reimbursement:*

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

Not Qualified for Mind and Body Reimbursement:

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

Find a Qualified Provider and Save

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

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

GET REIMBURSED IN THREE EASY STEPS

1

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

2

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

3

Mail
Send the completed form to the address listed.

Questions?

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

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

MIND AND BODY REIMBURSEMENT REQUEST

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

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

Subscriber Information (Policyholder)

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

Address — Number and Street	City	State	ZIP Code

Employer's Name

Claim Information

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

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

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

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

Total dollars requested: $ _____

Calendar year: _____

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

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

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

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

Important Information:

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

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HEALTH ENHANCEMENT PROGRAMS

MIIA Well Aware
Work Well, Live Well

PROGRAM	ELIGIBILITY	DESCRIPTION	GET STARTED
Employee Assistance Program (EAP)	All employees and their household members regardless of health plan status.	In-person, telephonic, or virtual counseling, training courses, management consultations, critical incident debriefing, work/life resources and support.	
Learn to Live	All employees and their household members (age 13+) regardless of health plan status.	Virtual programs, clinical assessments, and coaching based on Cognitive Behavioral Therapy. Address stress, anxiety & worry, depression, substance abuse, and more.	
Mindwise	All employees and their household members regardless of health plan status.	Anonymous, mental heath screening. 13 screening tools available for general wellbeing, anxiety, substance abuse, and more. Screenings may be completed for one's self, or on behalf of a loved one.	
Ompractice	All employees and their household members (age 13+) regardless of health plan status.	Live, virtual movement and mind/body classes including Yoga, Tai Chi, Pilates, HIIT, Meditation, and more!	
Quizzify	All* employees, and household members. *Only MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents are eligible for incentives.	Monthly jeopardy-like trivia game to help participants improve lifestyle, lower healthcare costs, and differentiate health facts from myths. One quiz is released per month.	
Quizzify2Go	All employees and their household members regardless of health plan status.	Mobile app providing sample questions to help prepare for over 165 types of doctor visits.	

Programs above are available at no cost to all employees regardless of health plan status.

HEALTH ENHANCEMENT PROGRAMS

For MIIA/Blue Cross Blue Shield Subscribers on an active plan.

MIIA Well Aware
Work Well. Live Well.

PROGRAM	ELIGIBILITY	DESCRIPTION	GET STARTED
2nd.MD	MIIA/Blue Cross Blue Shield Subscribers, spouses and dependents on an active health plan.	Virtual expert medical consultation and navigation service. Connect with Board Certified specialists about diagnosis, treatment plans, second opinions, and more.	
Ex Program	MIIA/Blue Cross Blue Shield Subscribers, spouses, and dependents 18+ on an active health plan.	Digital tobacco/vape cessation program in collaboration with Mayo Clinic. Access to online support community, live chat expert coaching, and nicotine gum/patches delivery when requested.	
Good Health Gateway	All MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents with Diabetes or Pre-Diabetes on an active health plan.	Diabetes management rewards program providing $0 copay for diabetes medications and supplies to those adherent to the program.	
Headspace	MIIA/Blue Cross Blue Shield Subscribers. Subscribers may enroll and invite 5 friends or family to join Headspace, free of charge (regardless of health plan status).	Mindfulness and Meditation app. Access the full Headspace library including content for sleep, focus, stress & anxiety, movement, and more.	
Hinge Health	MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents (age 18+) on an active health plan.	Virtual physical therapy to support muscle and joint health, decrease and prevent joint pain, to help live a healthy, and pain free life.	
Maven	MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents (age 18+) on an active health plan.	24/7 Virtual support for Family Building, Pregnancy, Parenting, and Menopause.	
Smart Shopper	MIIA/Blue Cross Blue Shield subscribers, spouses and dependents on an active health plan.	Cash back rewards on non-urgent medical procedures when using a preferred provider.	
Wellness Coaching	MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents (age 18+).	Up to 10 coaching sessions per year. Certified Wellness coaches provide guidance, accountability, and support to help you identify and meet goals specific to you and your lifestyle.	

Programs above are available at no cost to MIIA/Blue Cross Blue Shield Subscribers on an active plan.

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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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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.

MASSACHUSETTS | SmartShopper®

EARN MONEY WITH SMARTSHOPPER®

SmartShopper is an incentive and engagement program managed by Zelis®, 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. Rewards range from $15–$400, depending on the procedure. To find a reward-eligible doctor or hospital for your recommended procedure, sign in to **bluecrossma.com/myblue**, or call Zelis' Care Concierge Team at **1-877-281-3722**.

Keep this list for future reference.

Save on these health care services and procedure categories:		
Back surgery	Ear, nose, throat (ENT)	Mammogram
Bariatric surgery	Echocardiogram	MRI
Bladder repair for incontinence	Fine needle aspiration for biopsy with imaging	PET scan
Bladder scope	Gall bladder removal	Prostatectomy
Bone density study	Hammertoe correction	Reduction mammoplasty
Breast tumor biopsy or removal	Hepatobiliary system imaging	Repair finger tendon
Bronchoscopy	Hernia repair	Rotator cuff repair
Bunionectomy	Hip replacement	Shoulder arthroscopy
Cardiac ablation	Hysterectomy	Sigmoidoscopy
Cardiac nuclear imaging	Hysteroscopy	Sleep study
Carpal tunnel treatment	Kidney and ureter procedures for neoplasm	Total thyroidectomy
Cataract removal	Knee arthroscopy	Ultrasound
Cervical biopsy	Knee replacement	Upper GI endoscopy
Colonoscopy	Laparoscopic fibroid removal	Whole body bone scan
Coronary bypass	Laparoscopic removal of ovaries and/or fallopian tubes	X-ray
CT scan	Lithotripsy – fragmenting of kidney stones	

The dollar amount you receive may be considered taxable income. Consult your tax advisor.
SmartShopper is managed by Zelis®, 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 plans, only network providers located in Massachusetts may qualify for rewards.

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MASSACHUSETTS

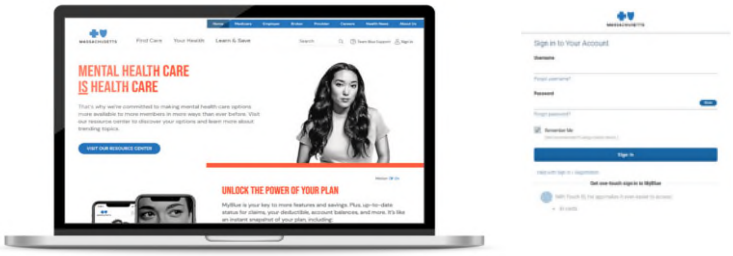
GETTING STARTED WITH SMARTSHOPPER®

Earning up to $400 is as easy as 1-2-3.

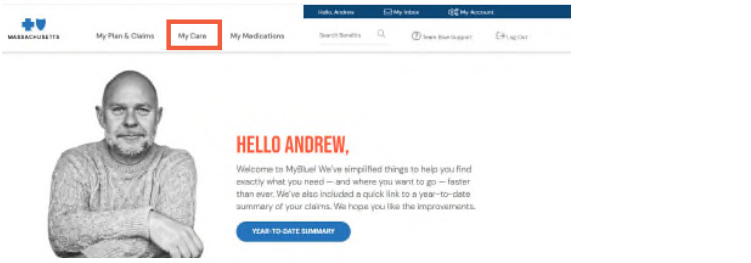
You can compare competitively priced care, and earn up to $400 in cash rewards after each eligible procedure when you use SmartShopper from Zelis®, an independent company. Getting started is easy. Just follow these four steps:

1 Sign in to **MyBlue** or create an account

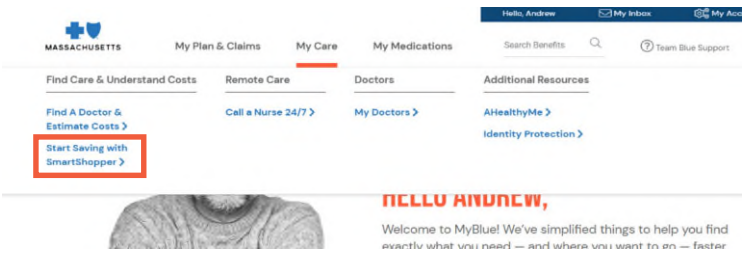
Visit **bluecrossma.org** to sign in, or click **Create Account** to register for a new one.



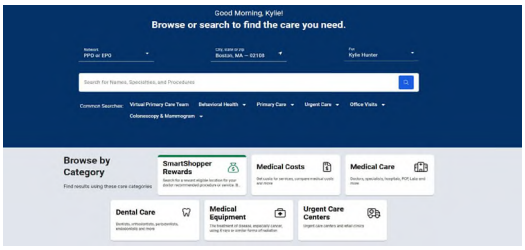
2 Go to **My Care**



3 Click **Start Saving** with **SmartShopper**



4 Search for provider **Names, Specialties** and **Procedures**



Questions?

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

MASSACHUSETTS

The dollar amount you receive may be considered taxable income. Consult your tax advisor. SmartShopper is managed by Zelis, an independent company. 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 plans, only network providers located in Massachusetts may qualify for rewards. 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.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

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

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

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

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

Complaint forms are available at **hhs.gov**.

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PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

Arabic/ةيبر:

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

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

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

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

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

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

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

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

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

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

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

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

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

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

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