MASSACHUSETTS

https://planinfo.bluecrossma.com/customblue/2022/miiatownofwenham

Effective: 7/1/2022

WELCOME MIIA TOWN OF WENHAM

New MIIA updates upon renewal in 2022

- The fitness and weight loss reimbursement has increased to $300 each

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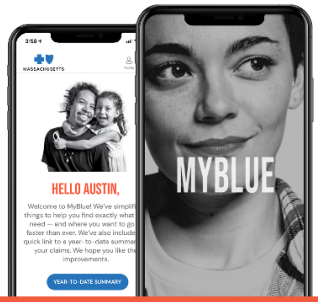
UNDERSTANDING YOUR PLAN AND BENEFITS



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- Well Connection
- Introduction Select Network
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- Dental Blue Freedom Fact Sheet
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- Pregnancy and Baby
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MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

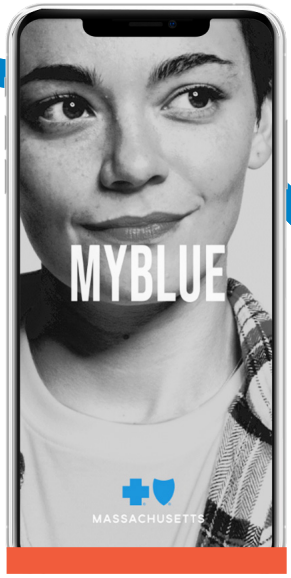
SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND $500 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

MIIA Town of Wenham

Plan-Year Deductible: $500/$1,000



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- CLAIMS AND BALANCES
- DIGITAL ID CARD

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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 most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible for medical benefits is **$500** per member (or **$1,000** per family) Your deductible for prescription drug benefits is **$100** per member (or **$200** per family).

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$2,500** per member (or **$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

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

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

When Outside the Service Area
If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

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

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $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	$10 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor for simple medical conditions • With the designated telehealth vendor for mental health services	Same as in-person visit $20 per visit, no deductible $10 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.
*** 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)***	$10 after deductible for Tier 1 $30 after deductible for Tier 2 $65 after deductible for Tier 3
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)***	$25 after deductible for Tier 1† $75 after deductible for Tier 2 $165 after deductible 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.
** Specialty drugs available only when obtained from a designated specialty pharmacy.
*** Cost share may be waived for certain covered drugs and supplies.
† Certain generic medications are available through the mail order pharmacy at $9, no deductible. For more information, go to bluecrossma.org/mail-order-pharmacy.

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

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

QUESTIONS?

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

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 member / $1,000 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, 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?	Yes. For prescription drugs, $100 member / $200 family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these 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.

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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 order supply	Not covered	Deductible applies first; up to 30-day retail (90-day designated retail or mail order) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / designated retail or mail order supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / designated retail or mail order supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first; when obtained from a designated specialty pharmacy; 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 required
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$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	$275 / admission; $1,500 / admission for certain hospitals	Not covered	Deductible applies first for general hospitals; pre-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
	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
	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	$500
■ 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*	$500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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

■ The plan's overall deductible	$500
■ 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*	$200
Copayments	$1,100
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	$500
■ 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	$500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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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**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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MASSACHUSETTS

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

SUMMARY OF BENEFITS

NETWORK BLUE® SELECT $500 DEDUCTIBLE

MIIA Town of Wenham

Plan-Year Deductible: $500/$1,000

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.

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YOUR CARE

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

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

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

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

You will not need prior authorization or referral to see an HMO Blue Select network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible for medical benefits is **$500** per member (or **$1,000** per family). Your deductible for prescription drug benefits is **$100** per member (or **$200** per family).

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$2,500** per member (or **$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

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

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

When Outside the Service Area
If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

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

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $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	$10 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor • With the designated telehealth vendor for mental health services	Same as in-person visit $20 per visit, no deductible $10 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.
*** 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)***	$10 after deductible for Tier 1 $30 after deductible for Tier 2 $65 after deductible for Tier 3
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)***	$25 after deductible for Tier 1† $75 after deductible for Tier 2 $165 after deductible 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.
** Specialty drugs available only when obtained from a designated specialty pharmacy.
*** Cost share may be waived for certain covered drugs and supplies.
† Certain generic medications are available through the mail order pharmacy at $9, no deductible. For more information, go to bluecrossma.org/mail-order-pharmacy.

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

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

QUESTIONS?

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

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 member / $1,000 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, 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?	Yes. For prescription drugs, $100 member / $200 family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these 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.

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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 order supply	Not covered	Deductible applies first; up to 30-day retail (90-day designated retail or mail order) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / designated retail or mail order supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / designated retail or mail order supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first; when obtained from a designated specialty pharmacy; 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
If you have a hospital stay	Facility fee (e.g., hospital room)	$275 / admission	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$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	$275 / admission	Not covered	Deductible applies first for general hospitals; pre-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
	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
	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	$500
■ 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*	$500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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

■ The plan's overall deductible	$500
■ 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*	$200
Copayments	$1,100
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	$500
■ 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	$500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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MASSACHUSETTS

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

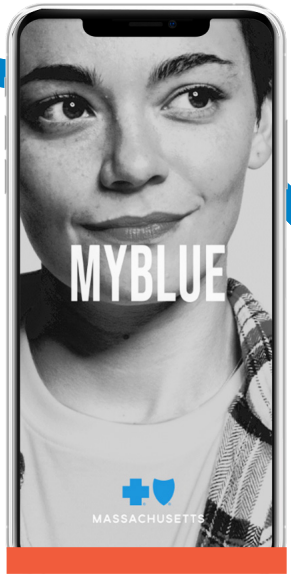
SUMMARY OF BENEFITS

BLUE CARE ELECT $500 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

MIIA Town of Wenham

Plan-Year Deductible: $500/$1,000



UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

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

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

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

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

YOUR CHOICE

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each calendar year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductibles for medical benefits are **$500** per member (or **$1,000** per family) for in-network services and **$500** per member (or **$1,000** per family) for out-of-network services. Your deductible for prescription drug benefits is **$100** per member (or **$200** per family).

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.

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

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

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

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

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

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

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

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

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

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$2,500** per member (or **$5,000** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your in-network deductible, you pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

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

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

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

Dependent Benefits
This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their dependent's 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: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)	$100 per visit after in-network deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit, no deductible $60 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Mental health or substance use treatment	$10 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor for simple medical conditions • With the designated telehealth vendor for mental health services	Same as in-person visit $20 per visit, no deductible $10 per visit, no deductible	Same as in-person visit Not applicable Not applicable
Chiropractors' office visits (up to 20 visits per calendar year)	$20 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	$60 per visit, no deductible	20% coinsurance after 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	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit***, no deductible $60 per visit***, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$250 per admission after deductible	20% coinsurance 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†	20% coinsurance after deductible 20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$275 per admission, no deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible	40% 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.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies** (up to a 30-day formulary supply for each prescription or refill)***	$10 after deductible for Tier 1 $30 after deductible for Tier 2 $65 after deductible for Tier 3	Not covered
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)***	$25 after deductible for Tier 1† $75 after deductible for Tier 2 $165 after deductible for Tier 3	Not covered

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Specialty drugs available only when obtained from a designated specialty pharmacy.
*** Cost share may be waived for certain covered drugs and supplies.
† Certain generic medications are available through the mail order pharmacy at $9, no deductible. For more information, go to bluecrossma.org/mail-order-pharmacy.

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

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

QUESTIONS?

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

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 member / $1,000 family in-network; $500 member / $1,000 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. In-network preventive and prenatal care, most office visits, therapy visits, and certain mental health services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. For prescription drugs, $100 member / $200 family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these 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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care; a telehealth cost share may be applicable
	Specialist visit	$60 / visit; $20 / chiropractor visit; $60 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 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	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; 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; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	$100	20% coinsurance	Deductible applies first; copayment applies per category of test / day; pre-authorization may be required

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 order supply	Not covered	Deductible applies first; up to 30-day retail (90-day designated retail or mail order) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / designated retail or mail order supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / designated retail or mail order supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first; when obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / admission	20% coinsurance	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	In-network deductible applies first for in-network and out-of-network services; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	In-network deductible applies first for in-network and out-of-network services
	Urgent care	$60 / 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)	$275 / admission; $1,500 / admission for certain hospitals	20% coinsurance	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 / 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	$275 / admission; $1,500 / admission for certain hospitals	20% coinsurance	Deductible applies first for general hospitals; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$275 / admission; $1,500 / admission for certain hospitals	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first except for in-network outpatient services; limited to 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	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	20% coinsurance	40% coinsurance	Deductible applies first; limited to 45 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	20% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth
	Hospice services	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% coinsurance for members with a cleft palate / cleft lip condition	Deductible applies first for out-of-network; limited to members under age 18

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Hearing aids ($5,000 per ear every 36 months)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($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**	**$500**
■ **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*	$500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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

■ **The plan's overall deductible**	**$500**
■ **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*	$200
Copayments	$1,100
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**	**$500**
■ **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	$500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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MASSACHUSETTS

MCC COMPLIANCE

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

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

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MASSACHUSETTS

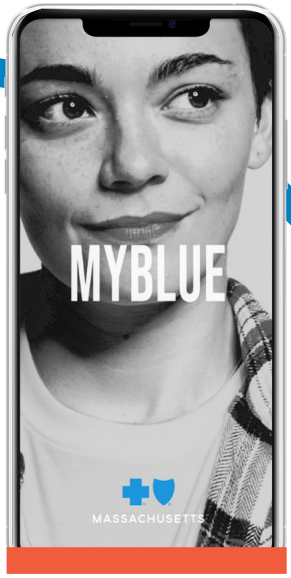
MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

SUMMARY OF BENEFITS

DENTAL BLUE® FREEDOM

(WITH ORTHODONTICS)

MIIA Town of Wenham



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.**

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DENTAL BLUE FREEDOM WITH ORTHODONTICS

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	$50 Per Member/$150 Per Family Calendar-Year Deductible (in-network and out-of-network combined)	
Full Coverage	90% Coverage	60% Coverage
$1,500 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 36 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 18). 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

$1,000 Lifetime Benefit Maximum

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

WELCOME TO DENTAL BLUE FREEDOM,

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

Your Dentist
Dental Blue Freedom offers a large network of dentists, including dentists in Massachusetts and Rhode Island who participate with Blue Cross Blue Shield of Massachusetts. Dental Blue Freedom members also have access to participating dentists nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

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

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

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

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

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

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

How 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 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.

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

$130 – 24/12/24 Frequency

Vision care service	In-network member cost	Out-of-network reimbursement[1]
Comprehensive eye exam	$20 copay	up to $50
Contact lens fit and follow-up[2]		
• Standard	up to $40	n/a
• Premium	10% off retail price	n/a
Retinal imaging	up to $39	n/a
Enhanced Diabetes Eye Care Benefit[3] 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	n/a
Frames	$130 allowance, then additional 20% off the balance	up to $74
Standard plastic lenses		
• Single vision	$25 copay	up to $42
• Bifocal	$25 copay	up to $78
• Trifocal	$25 copay	up to $130
• Lenticular	$25 copay	up to $130
• Standard progressive lens	$90 copay	up to $140
• Premium progressive lens		
Tier 1–Tier 3	$110–$135 copay	up to $196
Tier 4	$90 copay, then 80% of charge less $120 allowance	up to $196
Lens options[2]		
• UV treatment	$15	n/a
• Tint (solid and gradient)	$15	n/a
• Standard plastic scratch coating	$15	n/a
• Standard polycarbonate	$40	n/a
• Standard polycarbonate for covered dependents under age 19	Paid in full	up to $26
• Standard anti-reflective coating	$45	n/a
• Premium anti-reflective coating		
Tier 1–Tier 2	$57 - $68	n/a
• Photochromic/Transitions®˜ plastic	$75	n/a
• Polarized	20% off retail price	n/a
• Other add-ons	20% off retail price	n/a
Contact lenses[4]		
• Conventional	$130 allowance, then additional 15% off the balance	up to $104
• Disposable	$130 allowance	up to $104
• Medically necessary	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	

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

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

ADDITIONAL IN-NETWORK SAVINGS AND DISCOUNTS

40%

OFF A COMPLETE SECOND PAIR OF GLASSES

20%

OFF NON-PRESCRIPTION SUNGLASSES

15%

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

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

EyeMed

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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

SPECIAL OFFERS FOR ADDITIONAL SAVINGS

Find them at **blue2020ma.com**.

SAVE ON HEARING EXAMS AND HEARING AIDS

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

Questions?

Call customer service at **1-855-875-6948**.
To locate an in-network provider, visit **blue2020ma.com**.*

*Registration not required to search for providers.

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MASSACHUSETTS

Mail Order Pharmacy

The Mail Order Pharmacy Saves You Time and Money

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

Advantages of Using the Mail Order Pharmacy

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

How to Order Prescriptions

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

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

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

How to Order Refills

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

Have Your Prescriptions Refilled Automatically

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

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

Save up to **33%** **When you use the mail order pharmacy.****

*You can download and print a copy of the mail order form at **express-scripts.com.**
**Compared to three 30-day prescriptions purchased at a retail pharmacy.

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MASSACHUSETTS

GET TO KNOW THE MEDICATION LOOKUP TOOL

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

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

KEY FEATURES

Using the tool, you can:

SEARCH FOR ANY MEDICATION

See if it's covered by your plan

GET DETAILED INFORMATION

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

VIEW ADDITIONAL COVERAGE REQUIREMENTS

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

SEE COVERED ALTERNATIVES

For non-covered medications

Start Searching

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

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GETTING COVERAGE INFORMATION, SIMPLIFIED

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

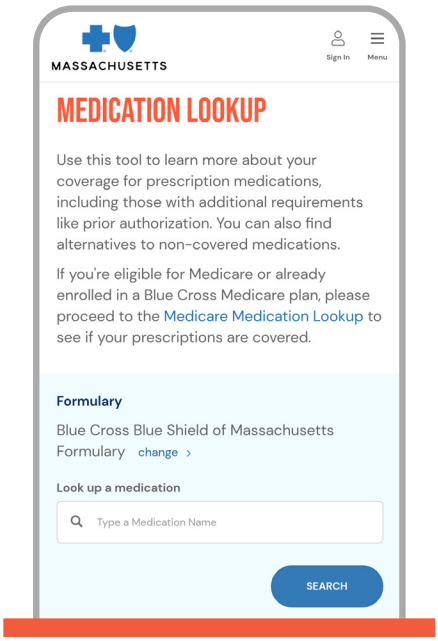
PERSONALIZED SEARCH

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

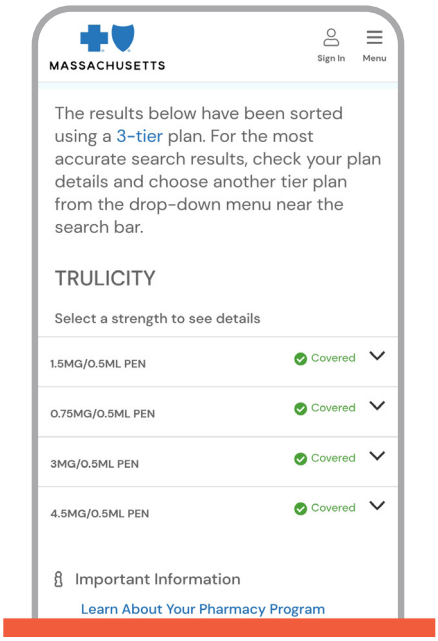
ANYONE CAN USE IT

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

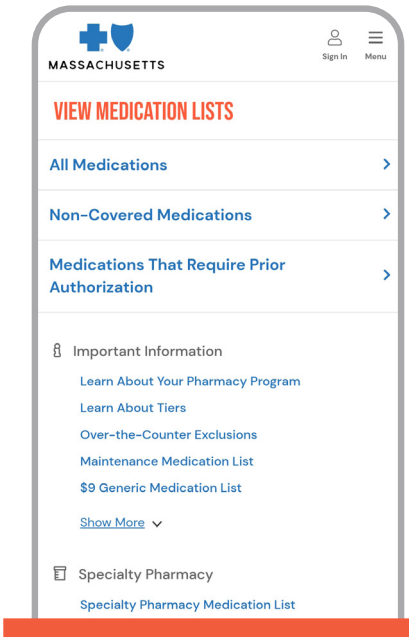
HOW TO USE THE TOOL



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



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



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

Learn More

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

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MASSACHUSETTS

THE CARE YOU NEED. WHENEVER AND WHEREVER.

Because guidance and advice should happen round the clock.

Learn more about your medical care options to save you time and money at **bluecrossma.org**.

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

- 24/7 NURSE LINE
- VIDEO DOCTOR VISIT
- DOCTOR'S OFFICE
- LIMITED SERVICE CLINICS
- URGENT CARE

Learn More

Visit **bluecrossma.org** to review your medical care options.

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24/7 NURSE LINE

When you're uncertain if your symptoms are serious or if an injury needs immediate care, get a nurse's advice 24/7, even on holidays. And get answers at no additional cost to you. Speak to a registered nurse. Call 1-888-247-BLUE (2583).

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

Cost: ▬▬▬▬
Time: ■▬▬▬
Severity: ▬▬▬▬

VIDEO DOCTOR VISIT

See a licensed doctor online in real time, without leaving home. Doctors on call on your device visit wellconnection.com.

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

Cost: ■▬▬▬
Time: ■▬▬▬
Severity: ■▬▬▬

DOCTOR'S OFFICE

Go to your doctor's office for scheduled checkups and for urgent health concerns that occur during office hours. Use Find a Doctor & Estimate Costs at bluecrossma.org.

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

Cost: ■▬▬▬
Time: ■■▬▬
Severity: ■▬▬▬

LIMITED SERVICE CLINICS

Go to a nearby clinic located within your local pharmacy for simple medical concerns.

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

Cost: ■■▬▬
Time: ■■▬▬
Severity: ■■▬▬

URGENT CARE

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

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

Cost: ■■▬▬
Time: ■■■▬
Severity: ■■■▬

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

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.

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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.

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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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INTRODUCING
HMO BLUE SELECT

Great Coverage, Even Greater Savings.

This health plan is a limited provider network plan, and 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. **Under this plan, members have access to network benefits from only 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 **www.bluecrossma.com/findadoctor** and select "HMO Blue Select."

MIIA Massachusetts Based Member Driven

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HMO BLUE SELECT

WHAT IS IT?

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

HMO BLUE SELECT

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 to access specialists and are also required to sign up for 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 access the closest medical facility.

HMO BLUE SELECT

HOW YOU SAVE

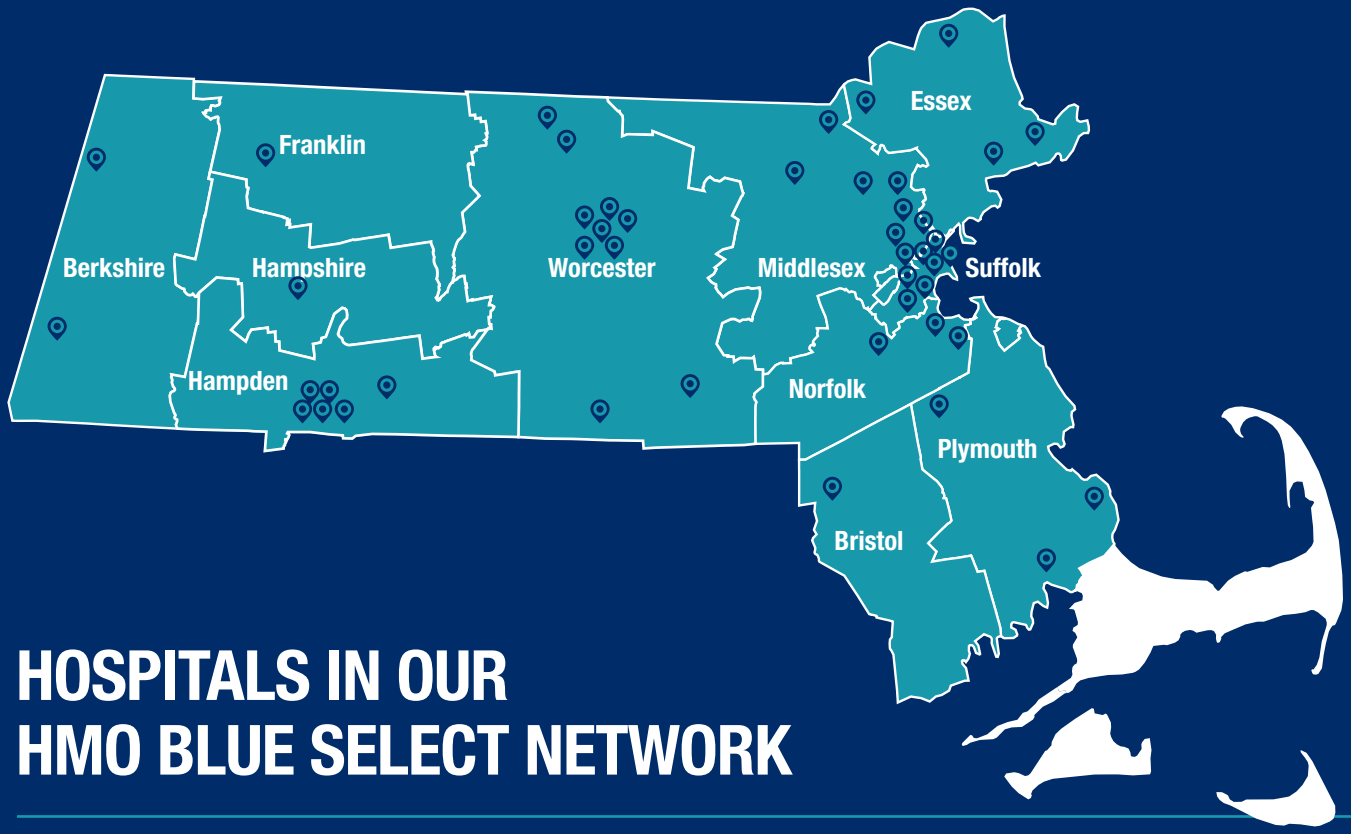
Getting the most value out of your plan is simple—your employees access care at lower-cost providers who are in the HMO Blue Select network. The savings will be reflected in lower health care costs for you.

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 but 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 are supporting and motivating providers to deliver care that works better.
You gain the flexibility to 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 closest medical facility without network restrictions.	**In Emergencies, Access Nationwide** HMO Blue Select allows members to access providers nationwide for emergency and urgent care whether they're traveling or on vacation.
Same great service from the brand you trust.	**Lower Cost. Excellent Service. Trusted Brand.** You and your employees will have peace of mind knowing that you'll receive the same high level 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 use 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
- 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
- The Shriner's Hospital for Children—Springfield
- Mercy Medical Center
- Holyoke Medical Center
- Noble Hospital

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
- 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
- New England Baptist Hospital
- Massachusetts Eye and Ear Infirmary
- The Shriner's Hopsital 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
- UMass Memorial Medical Center - Memorial
- UMass Memorial Medical Center - University
- Saint Vincent Hospital

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DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

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

HOW MAXIMUM ROLLOVER WORKS

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

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

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

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

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

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

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

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MASSACHUSETTS

DENTAL BLUE®
ENHANCED DENTAL BENEFITS

Additional Support for Members with Qualifying Conditions

The connection is clear: good oral health leads to better overall health. That's why your Dental Blue plan includes Enhanced Dental Benefits, a complete program that focuses on at-risk members with qualifying medical conditions. We offer additional, specific support, including full coverage for preventive and periodontal services that have been connected to improved overall health.

Condition	One cleaning or periodontal maintenance, 4 per calendar year[1]	Periodontal scaling, once per quadrant every 24 months[1]	Oral cancer screening, twice per calendar year	Fluoride treatment, 4 per calendar year
DIABETES	✓	✓		
CORONARY ARTERY DISEASE	✓	✓		
STROKE	✓	✓		
PREGNANCY	✓	✓		
ORAL CANCER	✓		✓	✓
SJÖGREN'S SYNDROME	✓		✓	✓

1. Periodontal maintenance and scaling are available on plans that offer periodontal benefits. There must be at least three months between a periodontal maintenance cleaning and any other cleanings covered under your dental plan, including these Enhanced Dental Benefits.

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

NO ADDITIONAL COST TO RECEIVE THESE EXTRA SERVICES*

Enhanced Dental Benefits are included with your dental coverage, at no additional cost. These services aren't subject to a deductible, co-insurance, or annual maximum when provided by a dentist in our network. If you have a PPO plan and choose to receive services from a dentist not in our network, you may be subject to co-insurance.

*Qualifying members only.

Questions?

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

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DENTAL BLUE® FREEDOM

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

PLAN HIGHLIGHTS

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

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

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

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

OUR NETWORKS

Dental Blue
Our traditional network offers you access to more than 90 percent of dentists in Massachusetts, as well as a large number of national dentists. Rates for services are slightly higher than those in our PPO network.

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

OUT-OF-NETWORK COVERAGE

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

HOW TO FIND IN-NETWORK DENTISTS

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

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

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Dental Blue®

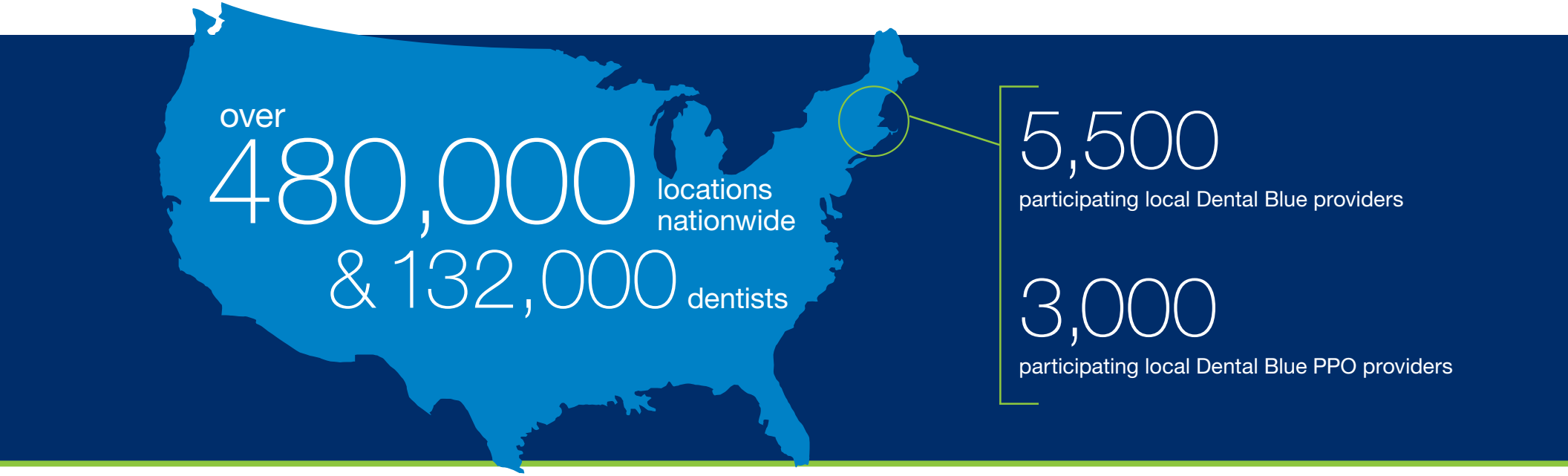
Dental Blue® Service Map

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

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

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

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



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

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NURSES RIGHT NOW. NO IFS, ANDS, OR BUTS.

Call our 24/7 Nurse Line 1-888-247-BLUE (2583).

Speak to a registered nurse, when you need to, day or night. Because guidance and advice should happen round the clock.

YES, YOUR PLAN COVERS IT!

Nurses are ready around the clock to answer your questions. Call our Nurse Line 24/7 to determine if you need immediate care.

GET CONNECTED DIRECTLY TO A NURSE

Immediate advice, no waiting for a callback.

365 DAYS A YEAR

Including holidays. For access that's ready when you are.

THERE'S NO ADDITIONAL COST

Because your health comes first.

EMAIL* A NURSE 24/7, TOO

Create an account to email a nurse for general questions or advice, day or night.

*We partner with Carenet Health℠, an independent health care engagement company, to administer this service. You'll need to create a Carenet Health account or sign in to their secure website. When creating your account, you'll need to enter your nine-digit Blue Cross member ID number. Please don't include the letter prefix.

Questions?

Visit **myblue.bluecrossma.com** and select **Find a Doctor & Estimate Costs** to find a provider near you. Download the MyBlue App from the App Store®℠ or Google Play™.

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MATERNITY CARE

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

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

Ovia Pregnancy App

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

Living Healthy Babies®

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

Call-in Maternity Support

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

Breast Pumps

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

Childbirth Course Reimbursement

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

Call-in Maternity Depression Care

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

Learn More

Get started at **bluecrossma.org/maternity**.

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FIND CARE

24/7 Nurse Line

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

Find a Doctor

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

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MASSACHUSETTS

THIS YEAR'S FLU SHOT IS CRUCIAL

COVID-19 means getting your flu shot is more important this year than ever.

It will help keep you, your family, and community from getting sick. And it could keep you all out of the doctor's office at a time when so many others may need critical care. Plus, getting your shot is no cost* and safe.[1]

LET'S DO THIS! HERE'S WHERE AND HOW TO GET YOUR SHOT

WHERE TO GET YOUR FLU SHOT

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

HOW TO FIND A VACCINE PROVIDER

- To find a provider, visit **vaccinefinder.org**
- Verify that the provider is part of our network by signing in to MyBlue at **bluecrossma.org**, and using the Find a Doctor tool
- To see if a pharmacy is in our network, sign in to your MyBlue account and click Express Scripts®˝ under **My Pharmacy** on the MyBlue home page
- If you need additional help, call Team Blue at **1-800-262-2583**

*CDC-recommended flu vaccines are covered in full when administered by an in-network provider. Exceptions may apply. Check your plan materials for details.

1. cdc.gov/flu/prevent/vaccinesafety.htm.

Myth: "The Flu Shot Will Make Me Sick"

Learn fact from fiction at **bluecrossma.org/flu**.

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YOUR BEST SHOT AT AVOIDING THE FLU

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

GET YOUR FLU SHOT

AVOID CLOSE CONTACT IN PUBLIC AND WITH PEOPLE WHO ARE SICK

WASH YOUR HANDS FREQUENTLY

AVOID TOUCHING YOUR EYES, NOSE, AND MOUTH

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

HOW DO I STAY SAFE WHEN I GO FOR MY SHOT?

Here are some tips when heading out:

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

LEARN MORE

Just about everyone 6 months and older should get the flu shot. Talk to your doctor to see if it's right for you, especially if you're 65 or older, or have a chronic health condition. Learn more about the flu and the flu shot at **bluecrossma.org/flu**.

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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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Nonprofit
Locally based
Member driven
Serving Massachusetts' communities since 1982

FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

$300

Qualified for Reimbursement:

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

Not Qualified for Reimbursement:

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

Get Started

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

Your reimbursement is waiting!

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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

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

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Member driven
Serving Massachusetts' communities since 1982

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.

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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.

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Programs Enhancing Member Health and Wellbeing

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

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

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BlueCross BlueShield

Worldwide Coverage

For Foreign and Domestic Travelers

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

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

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

An Association of Independent Blue Cross and Blue Shield Plans

Take this reference card with you when you travel.

When you need care, you'll be prepared.

TEAR HERE

Urgent Care

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

Your Passport to Good Health

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

FOLD HERE

Emergency Care

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

Getting Care in the United States

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

When you get service:

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

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

In Case of Emergency

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

Getting Care Outside the United States

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

TEAR HERE

BlueCross BlueShield

An Association of Independent Blue Cross and Blue Shield Plans

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Primary Care Provider's Name: _____

Doctor's Phone: _____

Doctor's Hospital Affiliation: _____

Your Blue Cross Blue Shield Member ID: _____

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

_____

For Inpatient Services:

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

For Outpatient Services:

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

Doctors and Hospitals

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

Your Member Responsibilities

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

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MASSACHUSETTS

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

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

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

Collection of Information

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

USE AND DISCLOSURE OF INFORMATION

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

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

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

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

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

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

OTHER DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION

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

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

YOUR PRIVACY RIGHTS

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

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

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

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

ABOUT THIS NOTICE

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

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

WHCRA NOTICE

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

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

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

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

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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.

MyBlue 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

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

- COVERAGE AND BENEFITS
- CLAIMS AND BALANCES
- FITNESS AND WEIGHT-LOSS REIMBURSEMENT
- MEDICATION LOOKUP

Sign In

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

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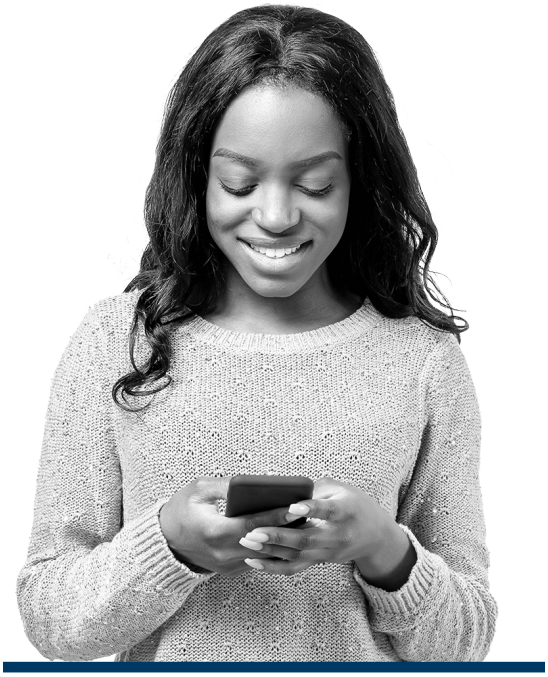
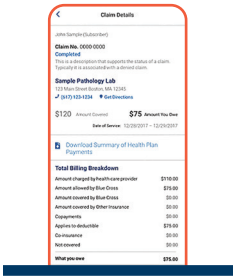
STAY ON TOP OF YOUR COVERAGE

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

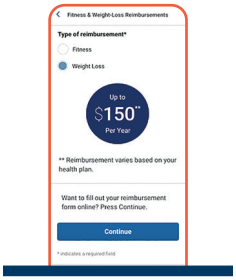
YOUR PLAN IN YOUR HAND



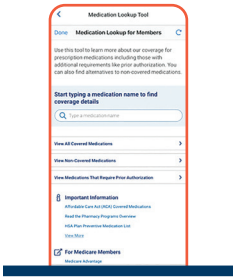
Once you sign in or create a MyBlue App account, you can see all of your benefits, all in one place.
Track your claims, medications, account balances, and more from your device. And, you can easily keep track of reimbursements and savings.



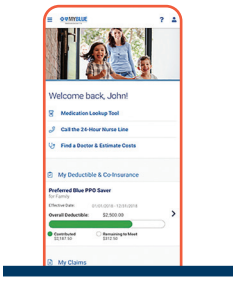
Track claims and benefits
Keep up to date on benefits and coverage.



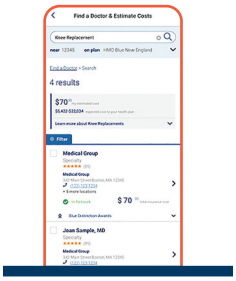
Fitness and weight-loss reimbursement
The online forms are here, along with other savings and offers.



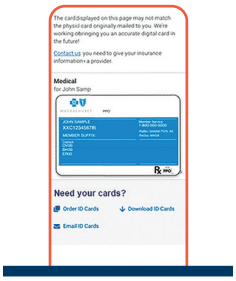
Your medications at a glance
Their names, costs, and prescriptions at your fingertips.



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™.

Download on the App Store | GET IT ON Google Play

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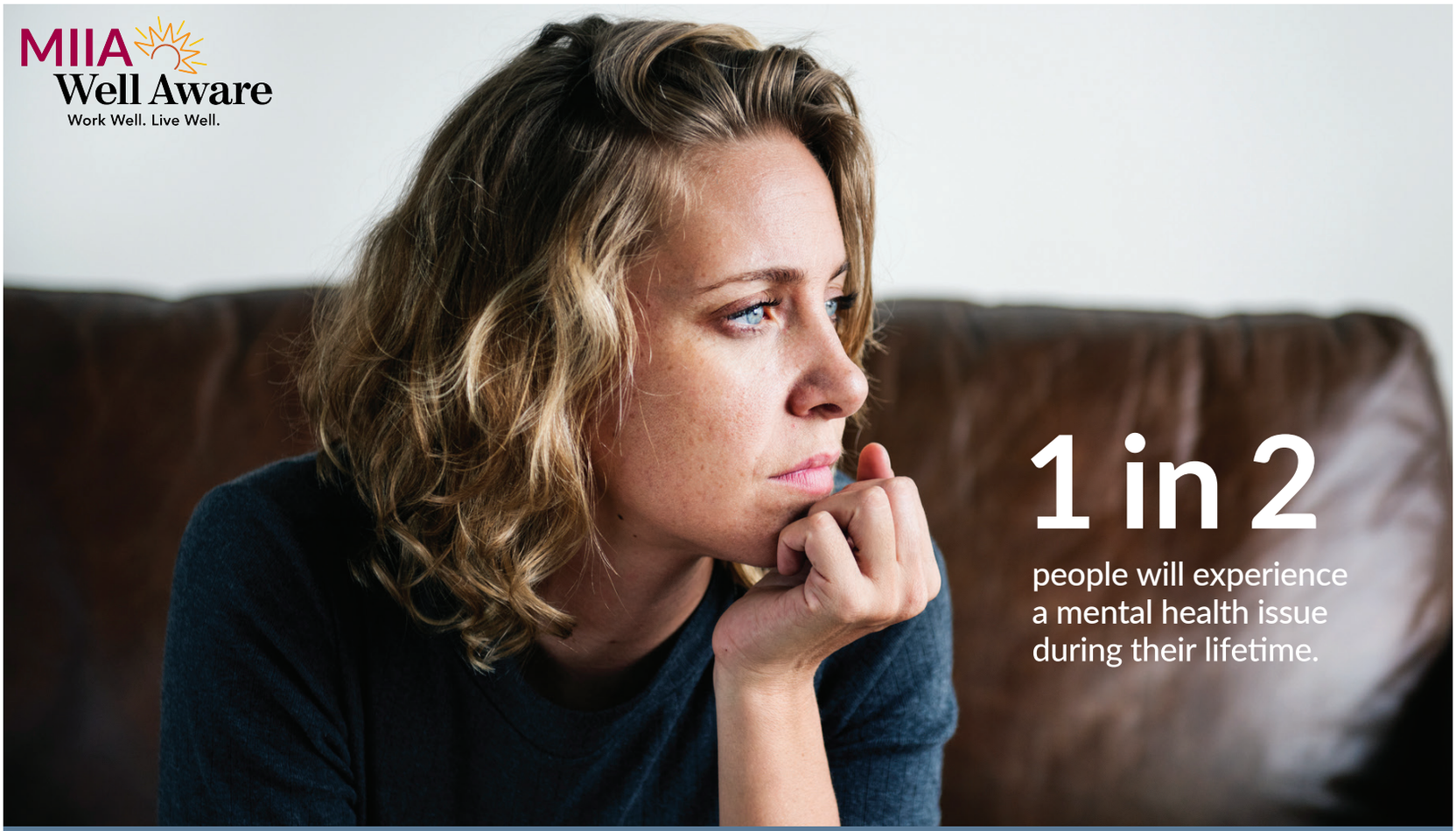
MIIA Well Aware
Work Well. Live Well.



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.

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

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Earn cash rewards with SmartShopper!

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

Medical procedure costs vary by location.

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

Here's how it works

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

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

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

Visit **bluecrossma.org** or call the SmartShopper Personal Assistant Team at **1-877-281-3722**. The Personal Assistant Team is available to help you shop, find a location, compare costs, confirm rewards and even schedule your appointment. Call today!

Go Green by going paperless! Contact us or scan this code to register your email today.

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

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

SmartShopper®

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

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

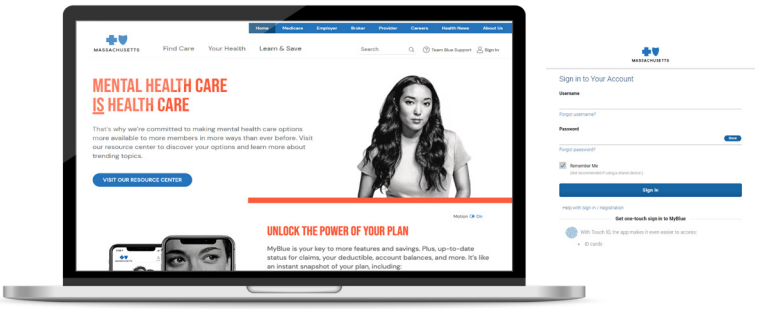
Earning up to $250 is as easy as 1-2-3.

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

1

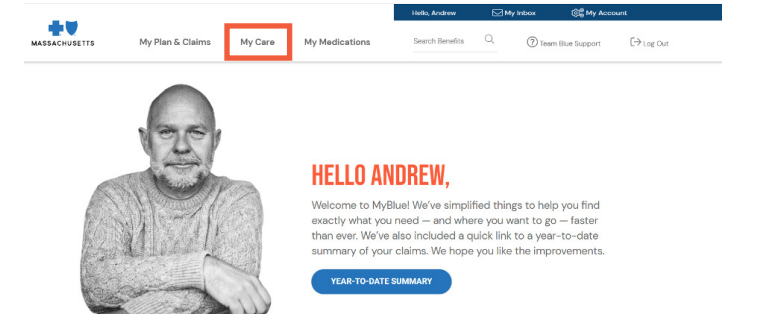
Sign in to **MyBlue** or create an account

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



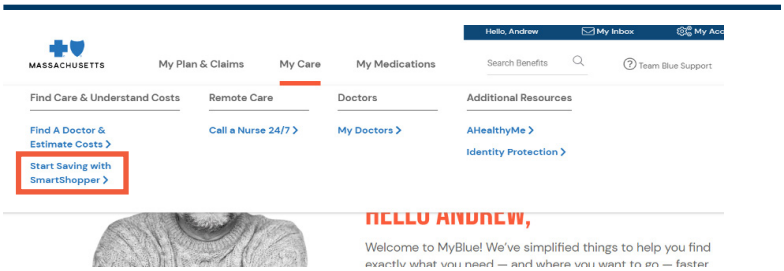
2

Go to **My Care**



3

Click **Start Saving with SmartShopper**



Questions?

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

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SmartShopper®

Earn Money with SmartShopper®´

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

Keep this list for future reference.

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

The dollar amount you receive may be considered taxable income. Consult your tax advisor.
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For HMO Blue New England plans, only network providers located in Massachusetts, Rhode Island, New Hampshire, and Vermont may qualify for rewards under the Smart Shopper program. For HMO Blue plans, only network providers located in Massachusetts may qualify for rewards.

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Nonprofit
Locally based
Member driven
Serving Massachusetts' communities since 1982

DIABETES CARE VALUE PROGRAM

A convenient approach to better diabetes management

The Diabetes Care Value program can help you adhere to your medication and take greater control of your health.

Powered by:

EXPRESS SCRIPTS®

HOW IT WORKS

We've partnered with Express Scripts®, an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts, to give you access to:

- A remote monitoring glucometer with mobile app
- Express Scripts pharmacists who specialize in diabetes

PROGRAM ELIGIBILITY

If you're eligible for the Diabetes Care Value program, Express Scripts will contact you with instructions on how to opt in.

Questions?

Call Member Service at the number on the front of your member ID card.

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KNOWLEDGE THROUGH NUMBERS

Remote Diabetes Monitoring from Express Scripts

Sync your Bluetooth®′-enabled OneTouch Verio®′ Flex Glucometer with the OneTouch Reveal®′ mobile app to record your blood sugar levels regularly.

Features of the OneTouch Verio Flex:

- Provided to you at no additional cost
- Logs test results and stores them within the app for easy reference
- Securely transmits data to Express Scripts' diabetes specialists

Adults living with diabetes who don't take their medication as prescribed experience:

1.5X

HIGHER EMERGENCY ROOM VISIT COSTS[1]

1.6X

HIGHER HOSPITAL COSTS[1]

DID YOU KNOW?

30 million adults in the U.S. are currently managing either type 1 or type 2 diabetes.[2]

33% of adults with diabetes don't take their medications regularly.[3]

Not taking prescribed diabetes medications adds $210 million in annual health care costs.[4]

1. Express Scripts, "Report: Adherence to Diabetes Rx," 2017.
2. Centers for Disease Control and Prevention, "National Diabetes Statistics Report," 2017.
3. Express Scripts, "Drug Report," 2016.
4. Express Scripts, "Diabetes Dilemma: U. S. Trends in Diabetes Medication Use," 2017.

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PHARMACY PROGRAM

SAVE TIME AND MONEY WITH $9 GENERIC MEDICATIONS

You can pay just $9 for certain generic medications when you order a 90-day supply through our mail order pharmacy.

Express Scripts®', an independent company that administers your pharmacy benefit on behalf of Blue Cross Blue Shield of Massachusetts, will deliver your prescriptions straight to your door at no additional cost. With fewer refills and no trips to the pharmacy, you'll be less likely to miss a dose, making it the most convenient and inexpensive way to get your medications.

Program Highlights

- Get a 90-day supply for $9
- Delivered to your door at no additional cost for standard shipping
- Fewer refills

See the Full List of $9 Generic Medications

1. Visit MyBlue at **bluecrossma.com/pharmacy**
2. Go to the **Mail Order Pharmacy** page
3. Click **View a list of $9 medications**

29% COST SAVINGS FOR EMPLOYEES, WHEN COMPARED TO RETAIL PHARMACIES[1]

TWO EASY WAYS TO GET HOME DELIVERY

Visit **express-scripts.com/starthd**

Call **1-800-892-5119**

1. Average percentage savings figure based on analysis of actual January–March 2012 claims for clients with a retail pharmacy and mail pharmacy benefit, excluding Medicare clients and clients participating in mandatory mail programs. Savings may vary based on your plan design.

Questions?

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

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MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts Formulary: $9 Generic Medication List

Last Updated: January 1, 2022
Valid Until: July 1, 2022

The following list includes generic medications covered by plans with the Blue Cross Blue Shield of Massachusetts Formulary. Members can get these medications in 90–day supplies for $9[1] when they order them through the mail order pharmacy available through Express Scripts®', an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts.

Normal prescription guidelines apply, which in some cases result in prescription supplies for less than 90 days. If your copayment for a 90–day supply through the mail order pharmacy is less than $9, you'll pay the lesser amount. The $9–or–less price is based only on a 90–day supply of each generic medication.[2] The price of the medication may differ if the quantity purchased is different.

This isn't a complete list of covered medications, and inclusion on the list doesn't guarantee coverage.[3] You must have a valid prescription from a licensed health provider to receive coverage for these medications. Some medications may also be subject to pharmacy management programs, such as Step Therapy, Prior Authorization, or Quality Care Dosing, or have other coverage requirements.

$9 Generic Medications Included in the National Preferred Formulary (NPF)

The generic medications listed in this document are also included in the National Preferred Formulary (NPF), which is available through Express Scripts. Pharmacy management program requirements apply to generic medications included in the NPF.

Learn More About Your Coverage

For more information about your pharmacy benefits, including the NPF and the medications listed in this document, sign in to your MyBlue account at **bluecrossma.org**.

1. Medications and pricing are subject to change without notice, so you should always confirm your cost prior to filling a prescription. A processing fee may apply. In applicable states, sales tax may be added to the cost of your prescriptions. Cost of standard shipping is included as part of your prescription plan. The coverage and prices of certain medications are also subject to the specific terms of your plan. Changes are made available to your Plan Sponsor.
2. Pre–packaged medications are only available for $9 in the package sizes specified.
3. Not all medications listed are covered by all prescription plans. Check your benefit materials for details.

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Drug Class	Medication Name	Strength	Form	$9 Quantity
Antibiotics/Antifungals/ Antivirals	ACYCLOVIR	200 MG	CAPSULE	180
	AMOXICILLIN	500 MG	TABLET	180
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	200 MG–28.5 MG	CHEW TABLET	60
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	400 MG–57 MG	CHEW TABLET	60
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	250 MG–125 MG	TABLET	30
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	500 MG–125 MG	TABLET	60
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	875 MG–125 MG	TABLET	60
	AMOXICILLIN TRIHYDRATE	250 MG	CAPSULE	180
	AMOXICILLIN TRIHYDRATE	500 MG	CAPSULE	180
	AMOXICILLIN TRIHYDRATE	125 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	300
	AMOXICILLIN TRIHYDRATE	200 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	300
	AMOXICILLIN TRIHYDRATE	250 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	240
	AMOXICILLIN TRIHYDRATE	250 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	300
	AMOXICILLIN TRIHYDRATE	250 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	450
	AMOXICILLIN TRIHYDRATE	400 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	300
	CEPHALEXIN MONOHYDRATE	250 MG	CAPSULE	90
	CEPHALEXIN MONOHYDRATE	500 MG	CAPSULE	180
	CIPROFLOXACIN HCL	250 MG	TABLET	90
	CIPROFLOXACIN HCL	500 MG	TABLET	180
	FLUCONAZOLE	150 MG	TABLET	3
	METRONIDAZOLE	250 MG	TABLET	270
	METRONIDAZOLE	500 MG	TABLET	42
	PENICILLIN V POTASSIUM	250 MG/5 ML	SUSPENSION, RECONSTITUTED	400
	PENICILLIN V POTASSIUM	250 MG/5 ML	SUSPENSION, RECONSTITUTED	900
	PENICILLIN V POTASSIUM	250 MG	TABLET	180

Drug Class	Medication Name	Strength	Form	$9 Quantity
Antibiotics/Antifungals/ Antivirals (Cont.)	PENICILLIN V POTASSIUM	500 MG	TABLET	180
	SULFAMETHOXAZOLE/TRIMETHOPRIM	400 MG–80 MG	TABLET	90
	SULFAMETHOXAZOLE/TRIMETHOPRIM	800 MG–160 MG	TABLET	180
	TERBINAFINE	250 MG	TABLET	90
Antiseizure Medications	ZONISAMIDE	25 MG	CAPSULE	180
Arthritis/Pain	DICLOFENAC SODIUM	50 MG	TABLET DR	180
	DICLOFENAC SODIUM	75 MG	TABLET DR	180
	IBUPROFEN	400 MG	TABLET	270
	IBUPROFEN	600 MG	TABLET	270
	IBUPROFEN	800 MG	TABLET	270
	INDOMETHACIN	25 MG	CAPSULE	270
	MELOXICAM	7.5 MG	TABLET	90
	MELOXICAM	15 MG	TABLET	90
	NAPROXEN	250 MG	TABLET	180
	NAPROXEN	375 MG	TABLET	180
	NAPROXEN	500 MG	TABLET	180
	NAPROXEN SODIUM	220 MG	TABLET	72
	NAPROXEN SODIUM	275 MG	TABLET	180
Asthma/Respiratory	ALBUTEROL SULFATE	0.83 MG/ML	SOLUTION	225
Behavioral Health	BENZTROPINE MESYLATE	0.5 MG	TABLET	180
	BENZTROPINE MESYLATE	2 MG	TABLET	180
	BUSPIRONE HCL	5 MG	TABLET	180
	BUSPIRONE HCL	10 MG	TABLET	180
	BUSPIRONE HCL	15 MG	TABLET	180
	CHLORDIAZEPOXIDE HCL	5 MG	CAPSULE	180
	CHLORDIAZEPOXIDE HCL	10 MG	CAPSULE	180
	CHLORDIAZEPOXIDE HCL	25 MG	CAPSULE	180
	CITALOPRAM HYDROBROMIDE	10 MG	TABLET	90
	CITALOPRAM HYDROBROMIDE	20 MG	TABLET	90
	CITALOPRAM HYDROBROMIDE	40 MG	TABLET	90
	CLONIDINE HCL	0.3 MG	TABLET	90
	DONEPEZIL HCL	5 MG	TABLET	90
	DONEPEZIL HCL	10 MG	TABLET	90
	DONEPEZIL HCL	5 MG	TABLET ODT	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Behavioral Health (Cont.)	DONEPEZIL HCL	10 MG	TABLET ODT	90
	DOXEPIN HCL	10 MG	CAPSULE	90
	DOXEPIN HCL	25 MG	CAPSULE	90
	FLUOXETINE HCL	10 MG	CAPSULE	90
	FLUOXETINE HCL	20 MG	CAPSULE	90
	FLUOXETINE HCL	40 MG	CAPSULE	90
	HYDROXYZINE PAMOATE	25 MG	CAPSULE	180
	IMIPRAMINE HCL	10 MG	TABLET	90
	IMIPRAMINE HCL	25 MG	TABLET	90
	IMIPRAMINE HCL	50 MG	TABLET	90
	LITHIUM CARBONATE	150 MG	CAPSULE	90
	LITHIUM CARBONATE	300 MG	CAPSULE	180
	LITHIUM CARBONATE	600 MG	CAPSULE	180
	LITHIUM CARBONATE	300 MG	TABLET SA	180
	MIRTAZAPINE	15 MG	TABLET	90
	MIRTAZAPINE	30 MG	TABLET	90
	MIRTAZAPINE	45 MG	TABLET	90
	NORTRIPTYLINE HCL	10 MG	CAPSULE	90
	NORTRIPTYLINE HCL	25 MG	CAPSULE	90
	PAROXETINE HCL	10 MG	TABLET	90
	PAROXETINE HCL	20 MG	TABLET	90
	PAROXETINE HCL	30 MG	TABLET	90
	PAROXETINE HCL	40 MG	TABLET	90
	SERTRALINE HCL	25 MG	TABLET	90
	TRAZODONE HCL	50 MG	TABLET	90
	TRAZODONE HCL	100 MG	TABLET	90
	TRAZODONE HCL	150 MG	TABLET	90
	TRIHEXYPHENIDYL HCL	2 MG	TABLET	180
	TRIHEXYPHENIDYL HCL	5 MG	TABLET	180
Blood Pressure/Heart Health	AMILORIDE-HYDROCHLOROTHIAZIDE	5 MG–50 MG	TABLET	90
	AMIODARONE HCL	200 MG	TABLET	90
	ATENOLOL	25 MG	TABLET	90
	ATENOLOL	50 MG	TABLET	90
	ATENOLOL	100 MG	TABLET	90
	BENAZEPRIL HCL	5 MG	TABLET	90
	BENAZEPRIL HCL	10 MG	TABLET	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Blood Pressure/Heart Health (Cont.)	BENAZEPRIL HCL	20 MG	TABLET	90
	BENAZEPRIL HCL	40 MG	TABLET	90
	BISOPROL-HYDROCHLOROTHIAZIDE	2.5 MG–6.25 MG	TABLET	90
	BISOPROL-HYDROCHLOROTHIAZIDE	5 MG–6.25 MG	TABLET	90
	BISOPROL-HYDROCHLOROTHIAZIDE	10 MG–6.25 MG	TABLET	90
	BISOPROLOL FUMARATE	5 MG	TABLET	90
	BISOPROLOL FUMARATE	10 MG	TABLET	90
	CARVEDILOL	3.125 MG	TABLET	180
	CARVEDILOL	6.25 MG	TABLET	180
	CARVEDILOL	12.5 MG	TABLET	180
	CARVEDILOL	25 MG	TABLET	180
	CLONIDINE HCL	0.1 MG	TABLET	90
	CLONIDINE HCL	0.2 MG	TABLET	90
	DILTIAZEM HCL	120 MG	CAPSULE SR	90
	DILTIAZEM HCL	30 MG	TABLET	180
	DILTIAZEM HCL	60 MG	TABLET	180
	DOXAZOSIN MESYLATE	1 MG	TABLET	90
	DOXAZOSIN MESYLATE	2 MG	TABLET	90
	DOXAZOSIN MESYLATE	4 MG	TABLET	90
	DOXAZOSIN MESYLATE	8 MG	TABLET	90
	ENALAPRIL MALEATE	2.5 MG	TABLET	90
	ENALAPRIL MALEATE	5 MG	TABLET	90
	ENALAPRIL MALEATE	10 MG	TABLET	90
	ENALAPRIL MALEATE	20 MG	TABLET	90
	ENALAPRIL-HYDROCHLOROTHIAZIDE	5 MG–12.5 MG	TABLET	90
	ENALAPRIL-HYDROCHLOROTHIAZIDE	10 MG–25 MG	TABLET	90
	FELODIPINE	2.5 MG	TABLET SR	90
	FELODIPINE	5 MG	TABLET SR	90
	FELODIPINE	10 MG	TABLET SR	90
	FUROSEMIDE	20 MG	TABLET	90
	FUROSEMIDE	40 MG	TABLET	90
	FUROSEMIDE	80 MG	TABLET	90
	HYDRALAZINE HCL	10 MG	TABLET	270
	HYDRALAZINE HCL	25 MG	TABLET	270

Drug Class	Medication Name	Strength	Form	$9 Quantity
Blood Pressure/Heart Health (Cont.)	HYDRALAZINE HCL	50 MG	TABLET	270
	HYDRALAZINE HCL	100 MG	TABLET	270
	HYDROCHLOROTHIAZIDE	12.5 MG	CAPSULE	90
	HYDROCHLOROTHIAZIDE	25 MG	TABLET	90
	HYDROCHLOROTHIAZIDE	50 MG	TABLET	90
	INDAPAMIDE	1.25 MG	TABLET	90
	INDAPAMIDE	2.5 MG	TABLET	90
	ISOSORBIDE MONONITRATE	30 MG	TABLET SR 24H	90
	ISOSORBIDE MONONITRATE	60 MG	TABLET SR 24H	90
	LABETALOL HCL	100 MG	TABLET	180
	LABETALOL HCL	200 MG	TABLET	180
	LABETALOL HCL	300 MG	TABLET	180
	LISINOPRIL	2.5 MG	TABLET	90
	LISINOPRIL	5 MG	TABLET	90
	LISINOPRIL	10 MG	TABLET	90
	LISINOPRIL	20 MG	TABLET	90
	LISINOPRIL	30 MG	TABLET	90
	LISINOPRIL	40 MG	TABLET	90
	LISINOPRIL-HYDROCHLOROTHIAZIDE	10 MG–12.5 MG	TABLET	90
	LISINOPRIL-HYDROCHLOROTHIAZIDE	20 MG–12.5 MG	TABLET	90
	LISINOPRIL-HYDROCHLOROTHIAZIDE	20 MG–25 MG	TABLET	90
	METHYLDOPA	250 MG	TABLET	180
	METOPROLOL TARTRATE	50 MG	TABLET	180
	METOPROLOL TARTRATE	100 MG	TABLET	180
	MINOXIDIL	2.5 MG	TABLET	180
	MINOXIDIL	10 MG	TABLET	90
	PRAZOSIN HCL	1 MG	CAPSULE	90
	PROPRANOLOL HCL	10 MG	TABLET	180
	PROPRANOLOL HCL	20 MG	TABLET	180
	PROPRANOLOL HCL	40 MG	TABLET	180
	PROPRANOLOL HCL	60 MG	TABLET	180
	PROPRANOLOL HCL	80 MG	TABLET	180
	QUINAPRIL HCL	5 MG	TABLET	90
	QUINAPRIL HCL	10 MG	TABLET	90
	QUINAPRIL HCL	20 MG	TABLET	90
	QUINAPRIL HCL	40 MG	TABLET	90
	QUINAPRIL-HYDROCHLOROTHIAZIDE	10 MG–12.5 MG	TABLET	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Blood Pressure/Heart Health (Cont.)	QUINAPRIL-HYDROCHLOROTHIAZIDE	20 MG–12.5 MG	TABLET	90
	QUINAPRIL-HYDROCHLOROTHIAZIDE	20 MG–25 MG	TABLET	90
	RAMIPRIL	1.25 MG	CAPSULE	90
	RAMIPRIL	2.5 MG	CAPSULE	90
	RAMIPRIL	5 MG	CAPSULE	90
	RAMIPRIL	10 MG	CAPSULE	90
	SOTALOL HCL	80 MG	TABLET	180
	SOTALOL HCL	240 MG	TABLET	180
	SPIRONOLACTONE	25 MG	TABLET	90
	TERAZOSIN HCL	1 MG	CAPSULE	90
	TERAZOSIN HCL	2 MG	CAPSULE	90
	TERAZOSIN HCL	5 MG	CAPSULE	90
	TERAZOSIN HCL	10 MG	CAPSULE	90
	TORSEMIDE	5 MG	TABLET	90
	TORSEMIDE	10 MG	TABLET	90
	TORSEMIDE	20 MG	TABLET	90
	TORSEMIDE	100 MG	TABLET	90
	TRANDOLAPRIL	1 MG	TABLET	90
	TRANDOLAPRIL	2 MG	TABLET	90
	TRANDOLAPRIL	4 MG	TABLET	90
	TRIAMTERENE-HYDROCHLOROTHIAZIDE	37.5 MG–25 MG	CAPSULE	90
	TRIAMTERENE-HYDROCHLOROTHIAZIDE	37.5 MG–25 MG	TABLET	90
	TRIAMTERENE-HYDROCHLOROTHIAZIDE	75 MG–50 MG	TABLET	90
	VERAPAMIL HCL	80 MG	TABLET	270
	VERAPAMIL HCL	120 MG	TABLET	90
	VERAPAMIL HCL	120 MG	TABLET SA	90
	VERAPAMIL HCL	180 MG	TABLET SA	90
	VERAPAMIL HCL	240 MG	TABLET SA	90
	WARFARIN SODIUM	1 MG	TABLET	90
	WARFARIN SODIUM	2 MG	TABLET	90
	WARFARIN SODIUM	2.5 MG	TABLET	90
	WARFARIN SODIUM	3 MG	TABLET	90
	WARFARIN SODIUM	4 MG	TABLET	90
	WARFARIN SODIUM	5 MG	TABLET	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Blood Pressure/Heart Health (Cont.)	WARFARIN SODIUM	6 MG	TABLET	90
	WARFARIN SODIUM	7.5 MG	TABLET	90
	WARFARIN SODIUM	10 MG	TABLET	90
Cold and Allergy Therapy	BENZONATATE	100 MG	CAPSULE	270
	CYPROHEPTADINE HCL	4 MG	TABLET	90
	DEXTROMETHORPHAN HBR/ PROMETHAZINE HCL	15 MG–6.25 MG/5 ML	SYRUP	360
	PROMETHAZINE HCL	6.25 MG/5 ML	SYRUP	360
	PROMETHAZINE HCL	12.5 MG	TABLET	90
	PROMETHAZINE HCL	25 MG	TABLET	90
	PROMETHAZINE HCL	50 MG	TABLET	270
Diabetes	GLIMEPIRIDE	1 MG	TABLET	90
	GLIMEPIRIDE	2 MG	TABLET	90
	GLIMEPIRIDE	4 MG	TABLET	180
	GLIPIZIDE	5 MG	TABLET	180
	GLIPIZIDE	10 MG	TABLET	180
	GLIPIZIDE	5 MG	TABLET OSM 24HR	90
	GLYBURIDE	1.25 MG	TABLET	90
	GLYBURIDE	2.5 MG	TABLET	90
	GLYBURIDE	5 MG	TABLET	180
	GLYBURIDE/METFORMIN HCL	5 MG–500 MG	TABLET	360
	METFORMIN HCL	500 MG	TABLET	180
	METFORMIN HCL	850 MG	TABLET	180
	METFORMIN HCL	1000 MG	TABLET	180
	METFORMIN HCL	500 MG	TABLET SR 24H	180
	METOPROLOL TARTRATE	25 MG	TABLET	180
Eye Health	BACITRACIN-POLYMYXIN B SULFATE	500–10KU/G	OINTMENT	10.5
	ERYTHROMYCIN BASE	5 MG/G	OINTMENT	10.5
	GENTAMICIN SULFATE	0.3%	DROPS	15
	NEOMYCIN POLYMYXIN B SULFATE DEXAMETHASONE	3.5–10 K–0.1	OINTMENT	10.5
	POLYMYXIN B SULFATE/TMP	10 K U–0.1%	DROPS	30
GI Drugs	HYOSCYAMINE SULFATE	0.125 MG	TABLET	270
	METOCLOPRAMIDE HCL	5 MG	TABLET	360
	METOCLOPRAMIDE HCL	10 MG	TABLET	360

Drug Class	Medication Name	Strength	Form	$9 Quantity
Heartburn/Ulcer	FAMOTIDINE	40 MG	TABLET	90
	RANITIDINE HCL	300 MG	TABLET	90
High Cholesterol	LOVASTATIN	10 MG	TABLET	90
	LOVASTATIN	20 MG	TABLET	90
	LOVASTATIN	40 MG	TABLET	90
	PRAVASTATIN SODIUM	10 MG	TABLET	90
	PRAVASTATIN SODIUM	20 MG	TABLET	90
	PRAVASTATIN SODIUM	40 MG	TABLET	90
Muscle Relaxants	BACLOFEN	10 MG	TABLET	270
	CYCLOBENZAPRINE HCL	5 MG	TABLET	90
	CYCLOBENZAPRINE HCL	10 MG	TABLET	90
	ORPHENADRINE CITRATE	100 MG	TABLET SA	180
	TIZANIDINE HCL	2 MG	TABLET	270
	TIZANIDINE HCL	4 MG	TABLET	270
Parkinson's Disease	BENZTROPINE MESYLATE	1 MG	TABLET	180
Skin Conditions	HYDROCORTISONE	2.5%	CREAM	90
	TRIAMCINOLONE ACETONIDE	0.5%	CREAM	180
Thyroid Therapy	LEVOTHYROXINE SODIUM	25 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	50 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	75 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	88 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	100 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	112 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	125 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	137 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	150 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	175 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	200 MCG	TABLET	90
	METHIMAZOLE	5 MG	TABLET	90
	METHIMAZOLE	10 MG	TABLET	90
Vitamins and Electrolytes	FOLIC ACID	1 MG	TABLET	90
	POTASSIUM CHLORIDE	10 MEQ	TABLET SR	90
Women's Health	ESTRADIOL	0.5 MG	TABLET	90
	ESTRADIOL	1 MG	TABLET	90
	ESTRADIOL	2 MG	TABLET	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Women's Health (Cont.)	LEVONORGESTREL-ETHINYL ESTRADIOL	0.15 MG–0.03 MG	TABLET	84
	MEDROXYPROGESTERONE ACETATE	2.5 MG	TABLET	90
	MEDROXYPROGESTERONE ACETATE	5 MG	TABLET	90
	MEDROXYPROGESTERONE ACETATE	10 MG	TABLET	90
	NORGESTIMATE-ETHINYL ESTRADIOL	7 DAYS X 3 28	TABLET	84
Other Medications	ALENDRONATE SODIUM	5 MG	TABLET	90
	ALENDRONATE SODIUM	10 MG	TABLET	90
	ALENDRONATE SODIUM	35 MG	TABLET	12
	ALENDRONATE SODIUM	70 MG	TABLET	12
	ALLOPURINOL	100 MG	TABLET	90
	ALLOPURINOL	300 MG	TABLET	90
	CHLORHEXIDINE GLUCONATE	0.12%	MOUTHWASH	1,419
	DEXAMETHASONE	0.5 MG	TABLET	90
	DEXAMETHASONE	0.75 MG	TABLET	90
	FLUDROCORTISONE ACETATE	0.1 MG	TABLET	90
	ISONIAZID	300 MG	TABLET	90
	LIDOCAINE HCL	20 MG/ML	SOLUTION	300
	MEGESTROL ACETATE	20 MG	TABLET	90
	METHYLPREDNISOLONE	4 MG	TABLET DS PK	63
	OXYBUTYNIN CHLORIDE	5 MG	TABLET	180
	PREDNISONE	1 MG	TABLET	360
	PREDNISONE	2.5 MG	TABLET	90
	PREDNISONE	5 MG	TABLET	90
	PREDNISONE	10 MG	TABLET	90
	PREDNISONE	20 MG	TABLET	90

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MASSACHUSETTS

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

INTRODUCING SMART90®´

Convenience. Savings. Smart.

Getting 90-Day Supplies of Certain Maintenance Medications Saves You Time and Money.
With Smart90, you can get 90-day supplies of certain maintenance medications from a CVS Pharmacy™ location or by mail order when you order them through Express Scripts®´, an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts. Maintenance medications, also known as long-term medications, are prescribed to treat chronic or ongoing conditions, such as high blood pressure or diabetes. To view a list of medications that are eligible for the Smart90 program, please visit **myblue.bluecrossma.com/90daymeds.**

Advantages of Using Smart90
Smart90 saves you time and money. You'll pay less for a 90-day supply than you would for three 30-day supplies of your maintenance medications. You'll also be less likely to miss a dose since you won't have to refill as often.

Where to Get Your 90-Day Prescriptions
You have the choice to pick up your 90-day supply at any of the 9,800 CVS Pharmacy retail locations nationwide, or have it delivered to you when ordered through Express Scripts. Either way, you pay the same amount.

Smart90 Pharmacies:
- Express Scripts
- CVS Pharmacy

*Includes CVS within a Target®´ location

SMART90 SAVINGS EXAMPLE**

Type of Prescription	What You Pay		
30-Day Prescription	Tier 1 Medication Copay[1] $15	Tier 2 Medication Copay[2] $30	Tier 3 Medication Copay $50
90-Day Smart90 Prescription	Tier 1 Medication Copay[1] $30	Tier 2 Medication Copay[2] $60	Tier 3 Medication Copay $150

**Example is for illustrative purposes only. Check your benefit materials for details about your pharmacy coverage.

[1,2] Most maintenance medications fall under tiers 1 and 2 on a three-tier plan.

Questions?

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

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HOW TO FILL YOUR PRESCRIPTIONS WITH SMART90

Using Express Scripts

Orders are usually processed within 48 hours. Delivery takes about eight day for refills, or 10 to 14 days for new prescriptions. You can check your order status anytime by signing in to **express-scripts.com** and clicking on **Order Status**.

To place your order:

Sign in or register at **express-scripts.com/90day**, or call Express Scripts at **1-800-892-5119**.

Express Scripts will contact your doctor to get your 90-day prescription, and then deliver it right to your door.

Using a CVS Pharmacy

Simply talk to your doctor, or bring your prescription to a CVS pharmacist and ask about getting a 90-day prescription.

To find a CVS:

1. Go to **CVS.com**
2. Click **Store Locator**
3. Search for a pharmacy near you

How to Switch from Mail Order to a CVS Pharmacy

If you're already receiving your 90-day prescriptions through mail order using Express Scripts, but want to switch to CVS Pharmacy, go to your local CVS and tell the pharmacist. Remember to cancel your auto-refills from Express Scripts.

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

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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**).

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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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