



WELCOME MIIA TOWN OF MAYNARD

GET THE MOST OUT OF YOUR PLAN



VISIT
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FIND A
DOCTOR



LOOK UP A
MEDICATION



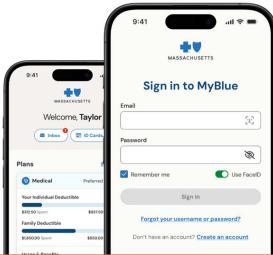
CONTACT US



SAVINGS
AND DEALS



UNDERSTANDING YOUR
PLAN AND BENEFITS



INTRODUCING THE NEW MYBLUE APP

The simplest way to tap into your health plan.

[Sign in to the MyBlue app.](#)

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BLUE CARE ELECT \$500 DEDUCTIBLE

Calendar-Year Deductible: \$500/\$1,000

MIIA Town of Maynard

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.



Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross and Blue Shield Association.



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 certain benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductibles 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.

When You Choose Preferred Providers

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

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

How to Find a Preferred Provider

To find a preferred provider:

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

When You Choose Non-Preferred Providers

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

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

Your Out-of-Pocket Maximum

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

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). 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.

Your Virtual Care Team

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

Value Care Offering Coverage

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

Utilization Review Requirements

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

Dependent Benefits

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows:		
• Ten visits during the first year of life	Nothing, no deductible	20% coinsurance after deductible
• 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		
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
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	\$150 per visit after deductible (copayment waived if admitted or for an observation stay)	\$150 per visit after in-network deductible (copayment waived if admitted or for an 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	\$20 per visit, no deductible	20% coinsurance after deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$35 per visit, no deductible	20% coinsurance after deductible
Mental health or substance use treatment	\$20 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services	Same as in-person visit \$20 per visit, no deductible	Same as in-person visit Only applicable in-network
• With a covered provider		
• With the in-network designated telehealth vendor		
Chiropractors' office visits	\$35 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	\$35 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$35 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$35 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	\$150 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	20% coinsurance after deductible**	40% coinsurance after deductible**
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by:		
• A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care	\$20 per visit***, no deductible	20% coinsurance after deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$35 per visit***, no deductible	20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$250 per admission after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible

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

** In-network cost share waived for one breast pump per birth, including supplies (20% coinsurance after deductible out-of-network).

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

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

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

** Cost share may be waived, reduced, or increased for certain covered drugs and supplies.

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

Wellness Participation Program

Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)

\$300 per calendar year per policy

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

\$300 per calendar year per policy

Mind and Body Wellness Program

Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)

\$300 per calendar year per policy

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

QUESTIONS?

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

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

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

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



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric <u>specialist</u> , nurse midwife, limited services clinic, multi-specialty <u>provider</u> group, or by a physician assistant or nurse practitioner designated as primary care; a telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$35 / visit; \$35 / chiropractor visit; \$35 / acupuncture visit	20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit	<u>Deductible</u> applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; <u>cost share</u> waived for at least one mental health wellness exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	\$150	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$45 / retail supply or \$90 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit	\$150 / visit	In-network <u>deductible</u> applies first for in-network and out-of-network services; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	In-network <u>deductible</u> applies first for in-network and out-of-network services
	<u>Urgent care</u>	\$35 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>cost share</u> may be waived or reduced for certain services; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$500 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 / admission	20% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	\$35 / visit for outpatient services; No charge for inpatient services	20% <u>coinsurance</u> for outpatient services; 20% <u>coinsurance</u> for inpatient services	<u>Deductible</u> applies first except for in-network outpatient services; limited to 100 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$35 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable
	<u>Skilled nursing care</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth, including supplies (20% <u>coinsurance</u> for out-of-network)
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services

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

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam per calendar year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$300 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.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
- Delivery fee copay
- Facility fee copay
- Diagnostic tests copay

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

<u>Deductibles</u>	\$500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$1,060

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible
- Specialist visit copay
- Primary care visit copay
- Diagnostic tests copay

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

<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

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

- The plan's overall deductible
- Specialist visit copay
- Emergency room copay
- Ambulance services copay

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

<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$800

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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NETWORK BLUE® NEW ENGLAND \$500 DEDUCTIBLE

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

MIIA Town of Maynard

UNLOCK THE POWER OF YOUR PLAN

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CLAIMS AND
BALANCES



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Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross and Blue Shield Association.



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

YOUR CARE

Your Primary Care Provider (PCP)

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

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

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

Referrals

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

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

Your Deductible

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

Your Out-of-Pocket Maximum

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

Emergency Room Services

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

Telehealth Services

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

Your Virtual Care Team

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

Value Care Offering Coverage

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

Service Area

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

When Outside the Service Area

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

Dependent Benefits

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one per calendar year)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$150 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	\$20 per visit, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$35 per visit, no deductible
Mental health or substance use treatment	\$20 per visit, no deductible
Outpatient telehealth services	Same as in-person visit \$20 per visit, no deductible
• With a covered provider	
• With the designated telehealth vendor	
Chiropractors' office visits	\$35 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$35 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$35 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$35 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, no deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by:	
• Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care	\$20 per visit***, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$35 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 or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible†
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission, no deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

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

** Cost share waived for one breast pump per birth, including supplies.

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

† Deductible waived for mental health admissions.

Covered Services**Your Cost****Prescription Drug Benefits*****At designated retail pharmacies**

(up to a 30-day formulary supply for each prescription or refill)**

No deductible

\$10 for Tier 1
\$25 for Tier 2
\$45 for Tier 3

Through the designated mail service or designated retail pharmacy

(up to a 90-day formulary supply for each prescription or refill)**

No deductible

\$20 for Tier 1
\$50 for Tier 2
\$90 for Tier 3

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

** Cost share may be waived, reduced, or increased for certain covered drugs and supplies. Retail drugs are available in a 90-day supply at three times the standard retail cost share.

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

Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)

\$300 per calendar year per policy

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

\$300 per calendar year per policy

Mind and Body Wellness Program

Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)

\$300 per calendar year per policy

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

QUESTIONS?

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

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

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

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



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$35 / visit; \$35 / chiropractor visit; \$35 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$100	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication	Generic drugs	In-Network (You will pay the least) \$10 / retail supply or \$20 / designated retail or mail service supply	Out-of-Network (You will pay the most) Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$45 / retail supply or \$90 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit	\$150 / visit	<u>Deductible</u> applies first; <u>copayment</u>
	<u>Emergency medical transportation</u>	No charge	No charge	<u>waived</u> if admitted or for observation stay
	<u>Urgent care</u>	\$35 / visit	\$35 / visit	<u>Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable</u>

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	\$35 / visit for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first except for outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a <u>telehealth cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$35 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a <u>telehealth cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam per calendar year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$300 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.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)

■ <u>The plan's overall deductible</u>	\$500
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$500
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$1,060

Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist visit copay</u>	\$35
■ <u>Primary care visit copay</u>	\$20
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
--------------------	---------

In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist visit copay</u>	\$35
■ <u>Emergency room copay</u>	\$150
■ <u>Ambulance services copay</u>	\$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$800

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

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003584365 (5/25) JB



MASSACHUSETTS

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

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ACCESS BLUE NEW ENGLAND SAVER

Plan-Year Deductible: \$2,000/\$4,000

MIIA Town of Maynard

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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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

Access

This plan gives you the option to go directly to a specialist or any doctor in the HMO Blue New England network without a referral. Just show your Blue Cross Blue Shield of Massachusetts ID card and receive care. However, some services do require authorization. See your benefit description for details.

Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to select a doctor who is accepting you and your family members as new patients and participates in our network of providers in New England. For children, you may designate 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.

Your provider may also work with Blue Cross Blue Shield of Massachusetts regarding Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$2,000** per individual membership (or **\$4,000** per family membership). **The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.**

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and prescription drug copayments for covered services. Your out-of-pocket maximum for medical and prescription drug benefits is **\$6,450** per member (or **\$12,900** 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 nothing for emergency room services.

Telehealth Services

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

Your Virtual Care Team

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

Value Care Offering Coverage

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

Service Area

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

When Outside the Service Area

If you are traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. See your benefit description for more information.

Dependent Benefits

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum after deductible
Routine vision exams (one per calendar year)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	Nothing after deductible
Office or health center visits	Nothing after deductible
Mental health or substance use treatment	Nothing after deductible
Outpatient telehealth services	Same as in-person visit
• With a covered provider	Nothing after deductible
• With the designated telehealth vendor	
Chiropractors' office visits (up to 20 visits per calendar year)	Nothing after deductible
Acupuncture visits (up to 12 visits per calendar year)	Nothing after deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	Nothing after deductible
Speech, hearing, and language disorder treatment—speech therapy	Nothing after deductible
Diagnostic x-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing 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	Nothing after deductible
Inpatient Care (including maternity care)	
General or 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)	Nothing after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

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

** Cost share waived for one breast pump per birth, including supplies.

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

\$25 after deductible for Tier 2

\$50 after deductible for Tier 3

Through the designated mail service pharmacy

(up to a 90-day formulary supply for each prescription or refill)**

\$20 after deductible for Tier 1

\$50 after deductible for Tier 2

\$110 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.

** Cost share may be waived, reduced, or increased for certain covered drugs and supplies.

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

Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)

\$300 per calendar year per policy

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

\$300 per calendar year per policy

Mind and Body Wellness Program

Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)

\$300 per calendar year per policy

 **24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.****QUESTIONS?****For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.**

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

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

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$2,000 individual contract / \$4,000 family contract.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive</u> care and prenatal care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	\$6,450 member / \$12,900 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	<u>Deductible</u> applies first; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$50 / retail supply or \$110 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	<u>Deductible</u> applies first; when obtained from a designated specialty pharmacy; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	No charge	No charge	<u>Deductible</u> applies first
	<u>Emergency medical transportation</u>	No charge	No charge	<u>Deductible</u> applies first
	<u>Urgent care</u>	No charge	No charge	<u>Deductible</u> applies first; out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable

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

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

Excluded Services & Other Covered Services:

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

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

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

• Acupuncture (12 visits per calendar year)	• Infertility treatment	• Weight loss programs (\$300 per calendar year per policy)
• Bariatric surgery	• Routine eye care - adult (one exam per calendar year)	
• Chiropractic care (20 visits per calendar year)	• Routine foot care (only for patients with systemic circulatory disease)	
• Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.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)

■ <u>The plan's overall deductible</u>	\$2,000
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$0
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$2,070

Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$2,000
■ <u>Specialist visit copay</u>	\$0
■ <u>Primary care visit copay</u>	\$0
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$2,000
■ <u>Specialist visit copay</u>	\$0
■ <u>Emergency room copay</u>	\$0
■ <u>Ambulance services copay</u>	\$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
--------------------	---------

In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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

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

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DENTAL BLUE® FREEDOM (WITH ORTHODONTICS)

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UNLOCK THE POWER OF YOUR PLAN
MyBlue gives you an instant snapshot of your plan:



Sign in

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



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DENTAL BLUE FREEDOM WITH ORTHODONTICS

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

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	\$25 Per Member/\$75 Per Family Calendar-Year Deductible (in-network and out-of-network combined)	
Full Coverage	80% Coverage	50% Coverage
\$1,000 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)		
Diagnostic <ul style="list-style-type: none"> One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months Bitewing X-rays twice per calendar year Single tooth X-rays as needed Study models and casts used in planning treatment once each 60 months Periodic or routine oral exams twice per calendar year Emergency exams 	Restorative <ul style="list-style-type: none"> Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period) Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period) Pin retention for fillings Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16) 	Prosthodontics (teeth replacement) <ul style="list-style-type: none"> Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable Adding teeth to an existing bridge Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)
Preventive <ul style="list-style-type: none"> Routine cleaning, scaling, and polishing of the teeth twice per calendar year Fluoride treatment twice per calendar year (members under age 19) Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per bicuspid or molar surface each 48 months. Space maintainers needed due to premature tooth loss (members under age 19) 	Oral Surgery <ul style="list-style-type: none"> Tooth extraction Root removal Biopsies 	Major Restorative (members age 16 or older) <ul style="list-style-type: none"> Crowns, once each 60 months for each tooth Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance. Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth Replacement of crowns, once each 60 months for each tooth Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance. Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth Post and core or crown buildup, once each 60 months for each tooth
	Periodontics (gum and bone) <ul style="list-style-type: none"> Periodontal scaling and root planing once per quadrant each 24 months Periodontal surgery once per quadrant each 36 months Periodontal maintenance following active periodontal therapy once each three months 	Implants (members age 16 or older) <ul style="list-style-type: none"> Single tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars
	Endodontics (roots and pulp) <ul style="list-style-type: none"> Root canal therapy (permanent teeth, once in a lifetime per tooth) Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth Therapeutic pulpotomy on primary or permanent teeth (members under age 16) Other endodontic surgery to treat or remove the dental root 	Orthodontic Benefit Group
	Prosthetic Maintenance <ul style="list-style-type: none"> Repair of partial or complete dentures, crowns, and bridges once each 12 months Adding teeth to an existing complete or partial denture Rebase or reline of dentures once each 36 months Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months 	50% Coverage for members up to age 19
	Other Services <ul style="list-style-type: none"> Occlusal adjustments once each 24 months Services to treat root sensitivity General anesthesia when administered in conjunction with covered surgical services Emergency dental care to treat acute pain or to prevent permanent harm to a member* 	No deductible <ul style="list-style-type: none"> 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 participating dentists in Massachusetts and nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

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

Your Benefits

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

The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and benefit maximum amounts shown in the chart. **For members under age 13, these benefits (not including orthodontic services) are covered in full up until the calendar-year benefit maximum.** The calendar year begins on January 1 and ends on December 31 of each year. The chart also shows the percentage of costs your plan will pay for covered dental services. Many of the covered services have specific time or age limits.

Pre-Treatment Estimates

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

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

Multi-Stage Procedures

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

How Network Dentists Are Paid – Preferred Dentists

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

How Network Dentists Are Paid – Participating Dentists

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

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

Benefits for covered services by a non-preferred or non-participating dentist are provided based on the allowed charge or the dentist's actual charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year or lifetime benefit maximum.

Orthodontic Benefits

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

When Coverage Begins

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

Dependent Benefits

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

Accumulated Maximum Rollover Benefits

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

Enhanced Dental Benefits

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

If You Have to File a Claim

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

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

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

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

Other Information

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

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

QUESTIONS?

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

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



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.

ATTENCIÓN: 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).



MASSACHUSETTS

NONDISCRIMINATION NOTICE

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

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

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

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

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

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

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

Complaint forms are available at hhs.gov.

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

Vietnamese/Tiếng Việt: LUU 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 (телефон: **711**).

Arabic/عَرَبِيَّة:

انتبه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النحني للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការដែនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាដំនឹងភាសាតំនើត តីអាជរកបានសម្រាប់អ្នក។ សូមទូរសព្ទទៅថ្មីកសេវាសមាជិកតាមលេខទ័រលើបណ្តុះសម្រាប់ខ្លួនរបស់អ្នក (TTY: **711**)។

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

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

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

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

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

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

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

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

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

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

Persian/پارسیان:

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

Lao/ລາວ: ຂໍ້ຄວນໄຟ້ໄຈ: ຖ້າເລື່ອງວິ້ພາວາວໄດ້, ມີການປໍວົງການຈ່ວຍເຫຼືອດ້ານພາກໃຫ້ທ່ານໂດຍ ບໍ່ແລ້ວຄ່າ. ໂທທາງົ່າຍປໍວົງການນະມາວິກທີ່ໝາຍເວັກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

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

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MASSACHUSETTS

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

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

\$130 Frame, \$25 Lens, 24/12/24 Frequency¹

Vision care service	In-network member cost at PLUS providers	In-network member cost	Out-of-network reimbursement ²
Comprehensive eye exam	\$0 copay	\$20 copay	up to \$50
Contact lens fit and follow-up³ • Standard • Premium	up to \$40 10% off retail price	up to \$40 10% off retail price	n/a n/a
Retinal imaging	up to \$39	up to \$39	n/a
Enhanced Diabetes Eye Care Benefit⁴ For members diagnosed with type 1 or type 2 diabetes	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	n/a
Frames	\$180 allowance, then additional 20% off the balance	\$130 allowance, then additional 20% off the balance	up to \$74
Standard plastic lenses • Single vision • Bifocal • Trifocal • Lenticular • Standard progressive lens • Premium progressive lens Tier 1-Tier 3 Tier 4	\$25 copay \$25 copay \$25 copay \$25 copay \$90 copay \$110-\$135 copay \$90 copay, then 80% of charge less \$120 allowance	\$25 copay \$25 copay \$25 copay \$25 copay \$90 copay \$110-\$135 copay \$90 copay, then 80% of charge less \$120 allowance	up to \$42 up to \$78 up to \$130 up to \$130 up to \$140 up to \$196 up to \$196
Lens options³ • UV treatment • Tint (solid and gradient) • Standard plastic scratch coating • Standard polycarbonate • Standard polycarbonate for covered dependents under age 19 • Standard anti-reflective coating • Premium anti-reflective coating Tier 1-Tier 2 • Photchromic/Transitions [®] plastic • Polarized • Other add-ons	\$15 \$15 \$15 \$40 Paid in full \$45 \$57-\$68 \$75 20% off retail price 20% off retail price	\$15 \$15 \$15 \$40 Paid in full \$45 \$57-\$68 \$75 20% off retail price 20% off retail price	n/a n/a n/a n/a up to \$26 n/a n/a n/a n/a n/a
Contact lenses⁵ • Conventional • Disposable • Medically necessary	\$130 allowance, then additional 15% off the balance \$130 allowance Paid in full	\$130 allowance, then additional 15% off the balance \$130 allowance Paid in full	up to \$104 up to \$104 up to \$210
Frequency • Exam • Lenses for frames or one order of contact lenses • Frames		once every 24 months once every 12 months once every 24 months	

1. For costs and further details about the coverage, including exclusions, refer to your plan materials. 2. Your actual expenses for covered services may exceed the stated out-of-network amount. 3. Indicates a service that is a discounted arrangement as part of your vision plan. 4. Consult with your eye care provider. 5. Discount applies to materials only and not to fittings for contact lenses.

BENEFITS YOU CAN SEE – FROM A COMPANY YOU TRUST



ACCESS TO ONE OF
THE NATION'S LARGEST
VISION NETWORKS



THOUSANDS OF
INDEPENDENT PROVIDERS



AWARD-WINNING
CUSTOMER SERVICE

FAVORITE NATIONAL RETAILERS

LENSCRAFTERS®

PEARLE OPTICAL

OPTICAL

and many regional retailers.

ONLINE SHOPPING OPTIONS

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

ADDITIONAL IN-NETWORK SAVINGS AND DISCOUNTS

40%

off a complete
second pair of glasses

20%

off non-prescription
sunglasses

15%

off retail price or
5% off promotional price
for laser vision correction
through U.S. Laser Network

SAVE ON HEARING EXAMS AND HEARING AIDS

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

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

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

Questions?

Call Blue 20/20 Customer Service at **1-855-875-6948**.

To locate an in-network provider, create an account at blue2020ma.com.



MASSACHUSETTS

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

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

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

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MASSACHUSETTS

DOCTORS ON CALL, ON YOUR DEVICE.

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



REAL DOCTORS. REAL EXPERIENCE. REALLY FAST.



GET MEDICAL CARE 24/7

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



THERAPY THAT COMES TO YOU

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



HIGHLY EXPERIENCED, HIGHLY RATED

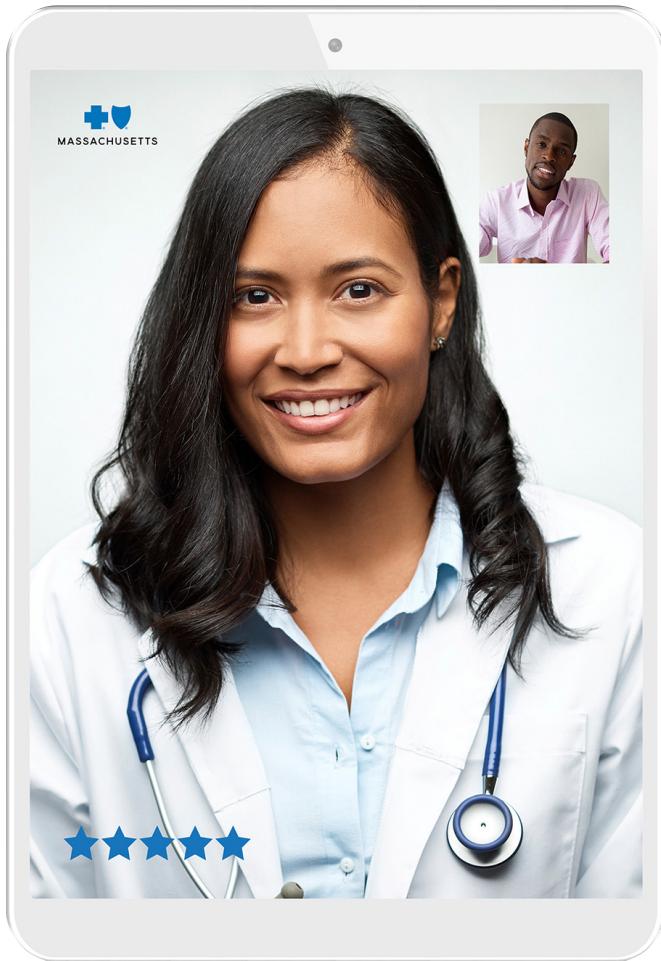
Qualified providers. Rated 4.8/5 stars and averaging 15 years of experience.²

Sign In

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

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

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



IS A VIDEO DOCTOR VISIT RIGHT FOR ME?

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

"I'm not feeling well."

Get care for:

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

"I need emotional support."

Talk to a therapist about:

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

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

"My loved one is under the weather."

If they're on your plan:

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



WELL CONNECTION IS HIGHLY RATED: 4.8 out of 5 Doctor and Provider rating from our members³

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

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

4. Prescription availability is defined by doctor judgment.

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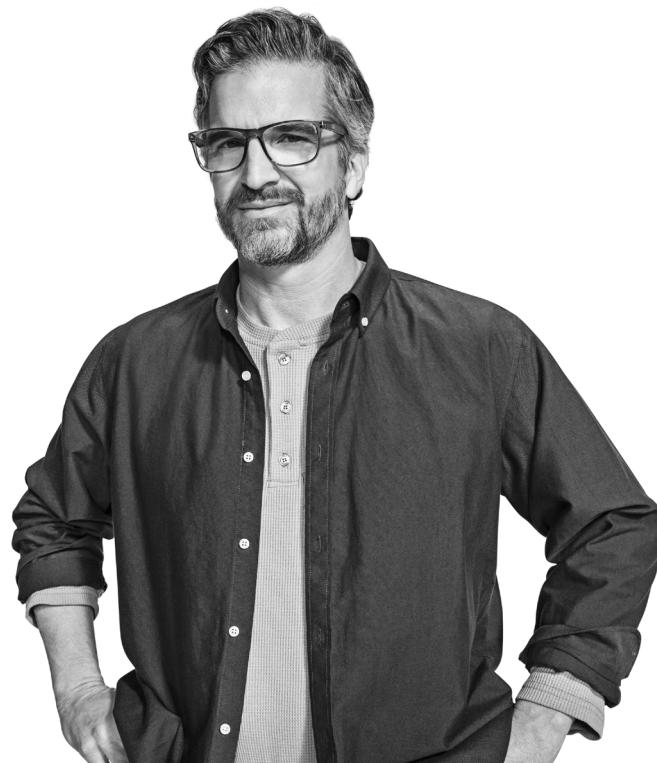
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MASSACHUSETTS

SAVE TIME AND MONEY WITH MAINTENANCE CHOICE VOLUNTARY

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



SWITCHING BRINGS BENEFITS



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



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



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



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

EXAMPLE OF HOW YOU CAN SAVE³

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

1. In most cases for eligible maintenance medications. Check plan materials for more details.

2. Maintenance Choice Voluntary isn't available in Oklahoma and West Virginia. If you're a resident of these states, you can still save money on your medications when you fill them in 90-day supplies at an in-network pharmacy that is able to dispense medications in 90-day supplies.

3. For illustrative purposes only, using a 3-tier plan.

(Continued)

HOW TO SWITCH TO 90-DAY FILLS



Participating retail pharmacy

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

To find a participating pharmacy:

- 1 Download the MyBlue app or create an account at bluecrossma.org.
- 2 Once signed in, click **Find a Pharmacy** under **My Medications**, then look for a pharmacy that offers 90-day supplies.



Mail service pharmacy

- 1 Download the MyBlue app or create an account at bluecrossma.org.
- 2 Once signed in, click **90-Day Mail Service Pharmacy** under **My Medications**.



STAY CONNECTED

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

- 1 Download the **MyBlue app** or create an account at bluecrossma.org.
- 2 Once signed in, click **Pharmacy Benefit Manager** under **My Medications**.
- 3 Go to **Profile**.
- 4 Select **Communication preferences** and enter your **email address**.

Questions?

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

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MASSACHUSETTS

SAVING SHOULD ALWAYS BE THIS EASY

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

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

There are two ways to be enrolled:

1. If you were already using coupons to help cover your costs for medications that you were taking before your plan year began, **you've been automatically enrolled in the program.** PillarRx Consulting, an independent company that administers the program, will call you to confirm your enrollment.
2. If you're not using coupons for an eligible medication at the beginning of your plan year, or you or your dependent start taking an eligible medication during the plan year, PillarRx will call you to discuss the program and help you enroll.

HOW THE PROGRAM WORKS



Fill your prescription

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



Enjoy instant savings

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



Get personalized, ongoing support

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

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

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

Questions?

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

(Continued)

What is a manufacturer's coupon?

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

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

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

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

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

Am I required to be enrolled in the program?

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

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

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

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

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

How does the program affect my deductible?

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

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

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

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

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

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

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

See if your medication is eligible

To see a list of eligible medications:

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

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

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

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HEALTH SAVINGS ACCOUNT (HSA)

PREVENTIVE MEDICATION LIST

For plans that use the:

Blue Cross Blue Shield of Massachusetts Formulary



THE PHARMACY THAT COMES TO YOU AND SAVES YOU MONEY

With the mail service pharmacy, most maintenance medications can be automatically refilled and shipped every 90 days at a lower cost.*

To start, create an account at bluecrossma.org.

Once signed in, click **Pharmacy Benefit Manager** under **My Medications**, then go to **Start Rx Delivery by Mail** under the **Prescriptions** tab. You can also call CVS Customer Care at **1-877-817-0477 (TTY: 711)**.

*Not all medications are available through the mail service pharmacy. Check your plan details to see if the mail service pharmacy is included with your plan.

PREVENTIVE MEDICATIONS COVERED BY HSA-QUALIFIED “SAVER” PLANS¹

The medications on this list are commonly prescribed to help you stay healthy by preventing complications or secondary conditions. Depending on your plan, you may not be required to pay the deductible for some of the medications. In some cases, your employer may also exempt the copayment or co-insurance. Check your benefit materials for details.

This isn't a complete list of covered medications, and inclusion on this list doesn't guarantee coverage.² You must have a valid prescription from a licensed health provider to receive coverage for these medications. Some medications may also be subject to pharmacy management programs, such as step therapy, prior authorization, or quality care dosing, or have other coverage requirements.

NOTE: Some medications on this list may be considered non-covered, including new medications under review by Blue Cross. Your doctor may request an exception for a non-covered medication when medically necessary.³

Learn more about your coverage

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

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

1. Blue Cross Blue Shield of Massachusetts plans that are HSA-qualified include the term “Saver” in the plan name.
For example: Blue Care Elect Saver or HMO Blue New England Saver \$2,000.

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

Medication class	Medication name
ACE inhibitors/angiotensin II receptor antagonists and combination agents	ACCUPRIL
	ACCURETIC
	ALTACE
	AMLODIPINE/BENAZEPRIL
	ATACAND
	ATACAND HCT
	AVALIDE
	AVAPRO
	BENAZEPRIL
	BENAZEPRIL/HYDROCHLOROTHIAZIDE
	BENICAR
	BENICAR HCT
	CANDESARTAN
	CANDESARTAN/HYDROCHLOROTHIAZIDE
	CAPTOPRIL
	CAPTOPRIL/HYDROCHLOROTHIAZIDE
	COZAAR
	DIOVAN
	DIOVAN HCT
	EDARBI
	EDARBYCLOR
	ENALAPRIL
	ENALAPRIL/HYDROCHLOROTHIAZIDE
	EPANED
	FOSINOPRIL
	FOSINOPRIL/HYDROCHLOROTHIAZIDE
	HYZAAR
	IRBESARTAN
	IRBESARTAN/HYDROCHLOROTHIAZIDE
	LISINOPRIL
	LISINOPRIL/HYDROCHLOROTHIAZIDE

Medication class	Medication name
ACE inhibitors/angiotensin II receptor antagonists and combination agents (continued)	LOSARTAN
	LOSARTAN/HYDROCHLOROTHIAZIDE
	LOTENSIN
	LOTENSIN HCT
	LOTREL
	MICARDIS
	MICARDIS HCT
	MOEXIPRIL
	OLMESARTAN
	OLMESARTAN/HYDROCHLOROTHIAZIDE
	PERINDOPRIL
	PRESTALIA
	QBRELIS
	QUINAPRIL
	QUINAPRIL/HYDROCHLOROTHIAZIDE
	RAMIPRIL
	TELMISARTAN
	TELMISARTAN/HYDROCHLOROTHIAZIDE
	TRANDOLAPRIL
	TRANDOLAPRIL/VERAPAMIL ER
	VALSARTAN
	VALSARTAN/HYDROCHLOROTHIAZIDE
	VASERETIC
	VASOTEC
	ZESTORETIC
	ZESTRIL
Agents for chemical dependency	ACAMPROSATE CALCIUM
	BRIXADI
	BUPRENORPHINE SUBLINGUAL
	BUPRENORPHINE/NALOXONE SUBLINGUAL
	DEPADE

Medication class	Medication name
Agents for chemical dependency (continued)	DISULFIRAM NALTREXONE SUBLOCADE SUBOXONE FILM VIVITROL ZUBSOLV
Allergenic extracts	GRASTEK ODACTRA ORALAIR PALFORZIA RAGWITEK
Anaphylaxis therapy agents	ADRENALIN ADYPHREN AUVI-Q EPINEPHRINE EPINEPHRINE PRO EPIPEN EPIPEN-JR EPISNAP SYMJEPI
Anti-arrhythmic agents	AMIODARONE BETAPACE BETAPACE AF DISOPYRAMIDE DOFETILIDE FLECAINIDE MULTAQ NORPACE NORPACE CR PACERONE PROPAFENONE

Medication class	Medication name
Anti-arrhythmic agents (continued)	PROPAFENONE ER SOTALOL SOTALOL AF SOTYLIZE TIKOSYN
Anti-coagulants	ARIXTRA DABIGATRAN ELIQUIS ENOXAPARIN FONDAPARINUX FRAGMIN JANTOVEN LOVENOX PRADAXA PRADAXA PAK SAVAYSA WARFARIN XARELTO
Anti-convulsants	APTIOM BANZEL BRIVIACT CARBAMAZEPINE CARBAMAZEPINE ER CARBATROL CELONTIN CLOBAZAM CLONAZEPAM DEPAKOTE DEPAKOTE ER DIACOMIT DILANTIN

Medication class	Medication name
Anti-convulsants (continued)	DIVALPROEX SODIUM DR
	DIVALPROEX SODIUM ER
	ELEPSIA XR
	EPIDIOLEX
	EPITOL
	EPRONTIA
	ETHOSUXIMIDE
	FELBAMATE
	FELBATOL
	FINTEPLA
	FYCOMPA
	KEPPRA
	KEPPRA XR
	KLONOPIN
	LACOSAMIDE
	LAMICTAL
	LAMICTAL XR
	LAMOTRIGINE
	LAMOTRIGINE ER
	LEVETIRACETAM
	LEVETIRACETAM ER
	METHSUXIMIDE
	MOTPOLY XR
	MY SOLINE
	ONFI
	OXCARBAZEPINE
	OXCARBAZEPINE ER
	OXTELLAR XR
	PHENOBARBITAL
	PHENYTEK
	PHENYTOIN

Medication class	Medication name
Anti-convulsants (continued)	PHENYTOIN SODIUM ER
	PRIMIDONE
	QUDEXY XR
	ROWEEPRA
	RUFINAMIDE
	SABRIL
	TEGRETOL
	TEGRETOL-XR
	TIAGABINE
	TOPAMAX
	TOPIRAMATE
	TOPIRAMATE ER
	TRILEPTAL
	TROKENDI XR
	VALPROIC ACID
	VIGABATRIN
	VIGAFYDE
	VIMPAT
	XCOPRI
	ZARONTIN
	ZONEGRAN
	ZONISADE
	ZONISAMIDE
	ZTALMY
Anti-depressants	AMITRIPTYLINE
	AMOXAPINE
	ANAFRANIL
	APLENZIN
	AUVELITY
	BUPROPION
	BUPROPION ER

Medication class	Medication name
Anti-depressants (continued)	CELEXA
	CITALOPRAM
	CYMBALTA
	DESIPRAMINE
	DESVENLAFAXINE ER
	DOXEPIN
	DRIZALMA SPRINKLE
	DULOXETINE DR
	EFFEXOR XR
	EMSAM
	ESCITALOPRAM
	FETZIMA
	FLUOXETINE
	FLUOXETINE 60 MG
	FLUOXETINE DR
	FORFIVO XL
	IMIPRAMINE HCL
	IMIPRAMINE PAMOATE
	IRENKA
	LEXAPRO
	MARPLAN
	MIRTAZAPINE
	NARDIL
	NORPRAMIN
	NORTRIPTYLINE
	OLEPTRO
	PAMELOR
	PARNATE
	PAROXETINE HCL
	PAROXETINE HCL ER
	PAXIL

Medication class	Medication name
Anti-depressants (continued)	PAXIL CR
	PHENELZINE
	PRISTIQ
	PROTRIPTYLINE
	PROZAC
	REMERON
	SERTRALINE
	TRANYLCYPROMINE
	TRAZODONE
	TRIMIPRAMINE
	TRINTELLIX
	VENLAFAXINE
	VENLAFAXINE ER
	VIIBRYD
	VILAZODONE
	WELLBUTRIN SR
	WELLBUTRIN XL
	ZOLOFT
Anti-estrogens	SOLTAMOX
	TAMOXIFEN
Anti-hyperlipidemics	ALTOPREV
	ANTARA
	ATORVALIQ
	ATORVASTATIN
	CHOLESTYRAMINE
	COLESEVELAM
	COLESTID
	COLESTIPL
	CRESTOR
	EZALLOR SPRINKLE
	EZETIMIBE

Medication class	Medication name
Anti-hyperlipidemics (continued)	FENOFIBRATE
	FENOFIBRIC ACID
	FENOFIBRIC ACID DR
	FENOGLIDE
	FIBRICOR
	FLOLIPID
	FLUVASTATIN
	FLUVASTATIN ER
	GEMFIBROZIL
	ICOSAPENT ETHYL
	LESCOL XL
	LIPITOR
	LIPOFEN
	LIVALO
	LOPID
	LOVASTATIN
	NEXLETOL
	NEXLIZET
	NIACIN ER
	NIACOR
	PITAVASTATIN
	PRALUENT
	PRAVASTATIN
	PREVALITE
	QUESTRAN/QUESTRAN LIGHT
	REPATHA
	ROSUVASTATIN
	SIMVASTATIN
	TRICOR
	TRILIPIX
	VASCEPA

Medication class	Medication name
Anti-hyperlipidemics (continued)	WELCHOL ZETIA ZOCOR ZYPITAMAG
Anti-malarial agents	ARAKODA ATOVAQUONE/PROGUANIL CHLOROQUINE MALARONE MEFLOQUINE PRIMAQUINE
Anti-manics	LITHIUM LITHIUM CARBONATE LITHIUM CARBONATE ER LITHOBID ER
Anti-obesity agents	CONTRAVE SAXENDA WEGOVY ZEPBOUND
Anti-psychotics	ABILIFY ABILIFY ASIMTUFII ABILIFY MAINTENA ABILIFY MYCITE ARIPIPRAZOLE ARISTADA ASENAPINE CAPLYTA CHLORPROMAZINE CLOZAPINE CLOZARIL EQUETRO FANAPT

Medication class	Medication name
Anti-psychotics (continued)	FLUPHENAZINE
	FLUPHENAZINE DECANOATE
	GEODON
	HALDOL DECANOATE
	HALOPERIDOL
	INVEGA
	INVEGA SUSTENNA
	INVEGA TRINZA
	LATUDA
	LOXAPINE
	LURASIDONE
	LYBALVI
	OLANZAPINE
	OLANZAPINE ORALLY DISINTEGRATING TABS
	PALIPERIDONE
	PERPHENAZINE
	PERSERIS
	QUETIAPINE
	QUETIAPINE ER
	REXULTI
	RISPERDAL
	RISPERDAL CONSTA
	RISPERIDONE
	RYKINDO
	SAPHRIS
	SECUADO
	SEROQUEL
	SEROQUEL XR
	THIORIDAZINE
	THIOTHIXENE
	TRIFLUOPERAZINE

Medication class	Medication name
Anti-psychotics (continued)	UZEDY VERSACLOZ VRAYLAR ZIPRASIDONE ZYPREXA ZYPREXA ZYDIS
Anti-retroviral agents	APRETUDE DESCOVY EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE 200/300 MG TRUVADA 200/300 MG
Aromatase inhibitors	ANASTROZOLE ARIMIDEX AROMASIN EXEMESTANE FEMARA LETROZOLE
Beta-blockers and combination agents	ACEBUTOLOL ATENOLOL ATENOLOL/CHLORTHALIDONE BETAXOLOL BISOPROLOL BISOPROLOL/HYDROCHLOROTHIAZIDE BYSTOLIC CARVEDILOL CARVEDILOL PHOSPHATE ER COREG COREG CR CORGARD INDERAL LA KAPSPARGO

Medication class	Medication name
Beta-blockers and combination agents (continued)	LABETALOL LEVATOL LOPRESSOR METOPROLOL METOPROLOL SUCCINATE ER METOPROLOL/HYDROCHLOROTHIAZIDE NADOLOL NEBIVOLOL PINDOLOL PROPRANOLOL PROPRANOLOL ER TENORETIC TENORMIN TIMOLOL MALEATE TOPROL-XL TRANDATE
Bowel preparations	CLENPIQ GAVILYTE GOLYTELY MOVIPREP OSMOPREP PEG 3350/ELECTROLYTES PLENVU SODIUM SULFATE/POTASSIUM SULFATE/MAGNESIUM SULFATE SUFLAVE SUPREP SUTAB
Calcium channel blockers and combination agents	AMLODIPINE CARDIZEM CARDIZEM CD

Medication class	Medication name
Calcium channel blockers and combination agents (continued)	CARDIZEM LA
	CARTIA XT
	CONJUPRI
	DILT-XR
	DILTIAZEM
	DILTIAZEM ER
	DILTIAZEM XR
	FELODIPINE ER
	ISOPTIN SR
	ISRADIPINE
	KATERZIA
	LEVAMLODIPINE
	MATZIM LA
	NICARDIPINE
	NIFEDIAC CC
	NIFEDIPINE
	NIFEDIPINE ER
	NISOLDIPINE ER
	NORLIQVA
	NORVASC
	PROCARDIA XL
	SULAR
	TIAZAC
	VERAPAMIL
	VERAPAMIL ER
	VERELAN
	VERELAN PM
Combination anti-hyperlipidemics	AMLODIPINE/ATORVASTATIN
	CADUET
	EZETIMIBE/SIMVASTATIN
	VYTORIN

Medication class	Medication name
Contraceptives	ALL PRESCRIPTION FORMULATIONS
Dental caries prevention	PEDIATRIC MULTIVITAMINS WITH FLUORIDE – ALL PRESCRIPTION FORMULATIONS
	SODIUM FLUORIDE
Diagnostic agents and supplies	BLOOD GLUCOSE STRIPS – ALL FORMULATIONS
	CONTROL SOLUTIONS
	INSULIN DELIVERY DEVICES
	INSULIN SYRINGES, INFUSION SETS, AND NEEDLES – ALL FORMULATIONS
	KETONE BLOOD TEST STRIPS – ALL FORMULATIONS
	LANCETS, LANCET DEVICES
	URINE TESTING STRIPS – ALL FORMULATIONS
Diuretics	ALDACTAZIDE
	AMILORIDE/HYDROCHLOROTHIAZIDE
	CHLORTHALIDONE
	DIURIL
	HYDROCHLOROTHIAZIDE
	INDAPAMIDE
	SPIRONOLACTONE/HYDROCHLOROTHIAZIDE
	THALITONE
	TRIAMTERENE/HYDROCHLOROTHIAZIDE
Hereditary angioedema agents	CINRYZE
	HAEGARDA
	ORLADEYO
	TAKHZYRO
Immunizations	ALL FORMULATIONS
Immunosuppressive agents	ASTAGRAF XL
	CELLCEPT
	CYCLOSPORINE CAPS
	ENVARSUS XR
	EVEROLIMUS
	GENGRAF

Medication class	Medication name
Immunosuppressive agents (continued)	MYCOPHENOLATE MOFETIL MYCOPHENOLATE SODIUM DR MYFORTIC MYHIBBIN NEORAL NULOJIX PROGRAF RAPAMUNE SANDIMMUNE SIROLIMUS TACROLIMUS ZORTRESS
Inhaled diabetes agents	AFREZZA
Injectable diabetes agents	ADMELOG APIDRA BASAGLAR BYDUREON BCISE BYETTA FIASP HUMALOG HUMULIN INSULIN ASPART INSULIN DEGLUDEC INSULIN GLARGINE INSULIN LISPRO LANTUS LEVEMIR LYUMJEV MOUNJARO MYXREDLIN NOVOLIN

Medication class	Medication name
Injectable diabetes agents (continued)	NOVOLOG OZEMPIC REZVOGLAR SEMGLEE SOLIQUA SYMLINPEN TOUJEO TRESIBA TRULICITY VICTOZA XULTOPHY
Miscellaneous	CHOLECALCIFEROL (D3) INPEFA LODOC
Multiple sclerosis agents	AUBAGIO AVONEX BAFIERTAM BETASERON BRIUMVI COPAXONE DIMETHYL FUMARATE DR EXTAVIA FINGOLIMOD GILENYA GLATIRAMER KESIMPTA LEMTRADA MAVENCLAD MAYZENT OCREVUS PLEGRIDY

Medication class	Medication name
Multiple sclerosis agents (continued)	PONVORY REBIF TASCENO ODT TECFIDERA TYSABRI VUMERITY ZEPOSIA
Obsessive compulsive disorder	CLOMIPRAMINE FLUVOXAMINE FLUVOXAMINE ER
Oral anti-anginal agents	ISORDIL ISOSORBIDE DINITRATE ISOSORBIDE MONONITRATE ISOSORBIDE MONONITRATE ER
Oral diabetes agents	ACARBOSE ACTOPLUS MET ACTOPLUS MET XR ACTOS ALOGLIPTIN ALOGLIPTIN/METFORMIN ALOGLIPTIN/PIOGLITAZONE AMARYL BEXAGLIFLOZON BRENZAVVY DAPAGLIFLOZIN DAPAGLIFLOZIN/METFORMIN ER DUETACT FARXIGA GLIMEPIRIDE GLIPIZIDE GLIPIZIDE ER

Medication class	Medication name
Oral diabetes agents (continued)	GLIPIZIDE/METFORMIN
	GLUCOTROL XL
	GLUMETZA
	GLYXAMBI
	INVOKAMET
	INVOKAMET XR
	INVOKANA
	JANUMET
	JANUMET XR
	JANUVIA
	JARDIANCE
	JENTADUETO
	JENTADUETO XR
	KAZANO
	METAGLIP
	METFORMIN
	METFORMIN ER
	MIGLITOL
	NATEGLINIDE
	NESINA
	ONGLYZA
	OSENI
	PIOGLITAZONE
	PIOGLITAZONE/GLIMEPIRIDE
	PIOGLITAZONE/METFORMIN
	QTERN
	REPAGLINIDE
	RIOMET
	RYBELSUS
	SAXAGLIPTIN
	SAXAGLIPTIN/METFORMIN ER

Medication class	Medication name
Oral diabetes agents (continued)	SEGLUROMET
	SITAGLIPTIN
	SITAGLIPTIN/METFORMIN
	STEGLATRO
	STEGLUJAN
	SYNJARDY
	SYNJARDY XR
	TRADJENTA
	TRIJARDY XR
	XIGDUO XR
	ZITUVIO
Osteoporosis	ACTONEL
	ALENDRONATE
	ATELVIA
	BINOSTO
	CALCITONIN
	CALCITONIN/SALMON
	EVENITY
	EVISTA
	FORTEO
	FOSAMAX
	FOSAMAX PLUS D
	IBANDRONATE
	MIACALCIN NASAL SPRAY
	PROLIA
	RALOXIFENE
	RECLAST
	RISEDRONATE
	TERIPARATIDE
	TYMLOS
	ZOLEDRONIC ACID 5 MG/100 ML

Medication class	Medication name
Other anti-hypertensive agents	ALISKIREN AMLODIPINE/OLMESARTAN AMLODIPINE/TELMISARTAN AMLODIPINE/VALSARTAN/HCTZ AZOR CATAPRES-TTS CLONIDINE CLONIDINE TRANSDERMAL EXFORGE EXFORGE HCT GUANFACINE HYDRALAZINE HYDROCHLOROTHIAZIDE METHYLDOPA MINOXIDIL OLMESARTAN/AMLODIPINE/HCTZ TEKTURN TEKTURN HCT TRIBENZOR TRYVIO
Platelet aggregation inhibitors	ASPIRIN 81 MG BRILINTA CLOPIDOGREL DIPYRIDAMOLE DIPYRIDAMOLE ER/ASPIRIN EFFIENT PLAVIX PRASUGREL YOSPRALA ZONTIVITY

Medication class	Medication name
Prenatal vitamins	ALL PRESCRIPTION FORMULATIONS
	FOLIC ACID
Respiratory agents	ACCOLATE
	ADVAIR
	ADVAIR HFA
	AIRDUO RESPICLICK
	ALVESCO
	ARNUITY ELLIPTA
	ASMANEX
	ASMANEX HFA
	BEYFORTUS
	BREO ELLIPTA
	BREYNA
	BUDESONIDE SUSPENSION
	BUDESONIDE/FORMOTEROL
	CINQAIR
	CROMOLYN SODIUM NEBULIZER SOLUTION
	DULERA
	FASENRA
	FLUTICASONE FUROATE/VILANTEROL
	FLUTICASONE PROPIONATE DISKUS
	FLUTICASONE PROPIONATE HFA
	FLUTICASONE/SALMETEROL
	MONTELUKAST
	NUCALA
	PULMICORT
	PULMICORT FLEXHALER
	QVAR REDIHALER
	SINGULAIR
	SPIRIVA RESPIMAT 1.25 MCG
	SYMBICORT

Medication class	Medication name
Respiratory agents (continued)	SYNAGIS TEZSPIRE TRELEGY ELLIPTA WIXELA INHUB XOLAIR ZAFIRLUKAST ZILEUTON ER ZYFLO
Respiratory therapy supplies	PEAK FLOW METERS SPACER DEVICES SPACER SUPPLIES
Smoking deterrents	BUPROPION ER NICODERM CQ NICORETTE GUM NICORETTE LOZENGE NICOTINE POLACRILEX NICOTINE TRANSDERMAL NICOTROL INHALER NICOTROL NS VARENICLINE
Transdermal/topical anti-anginal agents	NITRO-BID NITRO-DUR NITROGLYCERIN TRANSDERMAL



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

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

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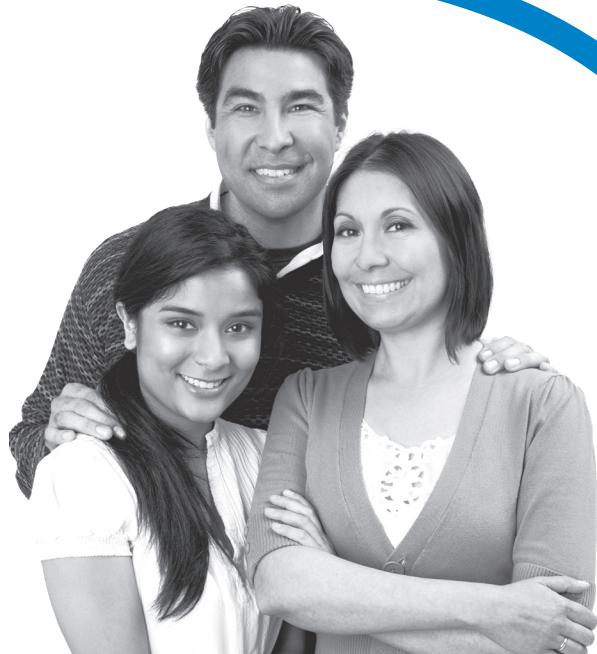
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MASSACHUSETTS

GET YOUR NO-COST FLU SHOT

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



WHERE TO GET YOUR SHOT

The flu shot is available at no additional cost² from in-network providers and locations, like a primary care provider or pharmacy. To find an in-network provider or location near you, go to bluecrossma.com/findadoctor.



LEARN MORE

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



1. CDC, "Seasonal Flu Vaccines," <https://www.cdc.gov/flu/ prevent/flushot.htm>.

2. Flu vaccines recommended by the CDC are covered in full when administered by an in-network provider. Exceptions may apply. Check plan materials for details.

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HEALTH ENHANCEMENT PROGRAMS



PROGRAM	ELIGIBILITY	DESCRIPTION	GET STARTED
Employee Assistance Program (EAP)	All employees and their household members regardless of health plan status.	In-person, telephonic, or virtual counseling, training courses, management consultations, critical incident debriefing, work/life resources and support.	Learn more about the EAP Get support from the EAP
Learn to Live	All employees and their household members (age 13+) regardless of health plan status.	Virtual programs, clinical assessments, and coaching based on Cognitive Behavioral Therapy. Address stress, anxiety & worry, depression, substance abuse, and more.	Learn more about Learn to Live Enroll in Learn to Live
Mindwise	All employees and their household members regardless of health plan status.	Anonymous, mental health screening. 13 screening tools available for general wellbeing, anxiety, substance abuse, and more. Screenings may be completed for one's self, or on behalf of a loved one.	Learn more about Mindwise Take a Mindwise mental health screening

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

HEALTH ENHANCEMENT PROGRAMS



PROGRAM	ELIGIBILITY	DESCRIPTION	GET STARTED
Ompractice	All employees and their household members (age 13+) regardless of health plan status.	Live, virtual movement and mind/body classes including Yoga, Tai Chi, Pilates, HIIT, Meditation, and more!	Learn more about Ompractice Register for Ompractice
Quizzify	All* employees, and household members. *Only MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents are eligible for incentives.	Monthly jeopardy-like trivia game to help participants improve lifestyle, lower healthcare costs, and differentiate health facts from myths. One quiz is released per month.	Learn more about Quizzify Register for Quizzify
Quizzify2Go	All employees and their household members regardless of health plan status.	Mobile app providing sample questions to help prepare for over 165 types of doctor visits.	Learn more about Quizzify2Go Visit the App or Google Play Store to download the Quizzify2Go app

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

HEALTH ENHANCEMENT PROGRAMS

For MIIA/Blue Cross Blue Shield Subscribers



PROGRAM	ELIGIBILITY	DESCRIPTION	GET STARTED
2nd.MD	MIIA/Blue Cross Blue Shield Subscribers, spouses and dependents on an active health plan.	Virtual expert medical consultation and navigation service. Connect with Board Certified specialists about diagnosis, treatment plans, second opinions, and more.	Learn more about 2nd.MD Activate 2nd.MD or call 1-866-269-3534
Ex Program	MIIA/Blue Cross Blue Shield Subscribers, spouses, and dependents 18+ on an active health plan.	Digital tobacco/vape cessation program in collaboration with Mayo Clinic. Access to online support community, live chat expert coaching, and nicotine gum/patches delivery when requested.	Learn more about the Ex Program Enroll in the Ex program
Good Health Gateway	All MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents with Diabetes or Pre-Diabetes on an active health plan.	Diabetes management rewards program providing \$0 copay for diabetes medications and supplies to those adherent to the program.	Learn more about Good Health Gateway Enroll in Good health Gateway

Programs above are available at no cost to MIIA/Blue Cross Blue Shield Subscribers.

HEALTH ENHANCEMENT PROGRAMS

For MIIA/Blue Cross Blue Shield Subscribers



PROGRAM	ELIGIBILITY	DESCRIPTION	GET STARTED
Headspace	MIIA/Blue Cross Blue Shield Subscribers. Subscribers may enroll and invite 5 friends or family to join Headspace, free of charge (regardless of health plan status).	Mindfulness and Meditation app. Access the full Headspace library including content for sleep, focus, stress & anxiety, movement, and more.	Learn more about Headspace Enroll in Headspace
Hinge Health	MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents (age 18+) on an active health plan.	Virtual physical therapy to support muscle and joint health, decrease and prevent joint pain, to help live a healthy, and pain free life.	Learn more about Hinge Health Enroll in Hinge Health
Maven	MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents (age 18+) on an active health plan.	24/7 Virtual support for Family Building, Pregnancy, Parenting, and Menopause.	Learn more about Maven Enroll in Maven

Programs above are available at no cost to MIIA/Blue Cross Blue Shield Subscribers.

HEALTH ENHANCEMENT PROGRAMS

For MIIA/Blue Cross Blue Shield Subscribers



PROGRAM	ELIGIBILITY	DESCRIPTION	GET STARTED
Smart Shopper	MIIA/Blue Cross Blue Shield subscribers, spouses and dependents on an active health plan.	Cash back rewards on non-urgent medical procedures when using a preferred provider.	<u>Learn more about Smart Shopper</u> Log into bluecrossma.org and click "Smart Shopper" or call 1-877-281-3722 to activate Smart Shopper.
Telephonic Wellness Coaching	MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents (age 18+).	Up to 10 coaching sessions per year. Certified Wellness coaches provide guidance, accountability, and support to help you identify and meet goals specific to you and your lifestyle.	<u>Learn more about Wellness Coaching</u> <u>Get started with a Certified Wellness Coach</u>

Programs above are available at no cost to MIIA/Blue Cross Blue Shield Subscribers.

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GETTING MORE. NOW THERE'S A PLAN.

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

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



UNLOCK THE POWER OF YOUR PLAN

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



COVERAGE
AND BENEFITS



CLAIMS AND
BALANCES



FITNESS AND WEIGHT-
LOSS REIMBURSEMENT



MEDICATION
LOOKUP



VIDEO
DOCTOR VISITS USING
WELL CONNECTION

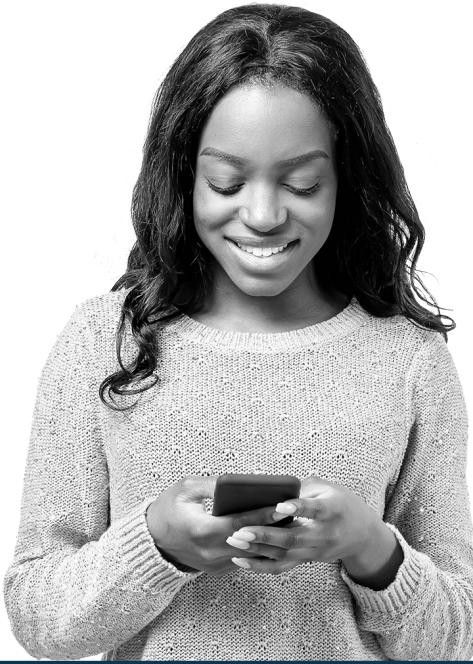
Get the App

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

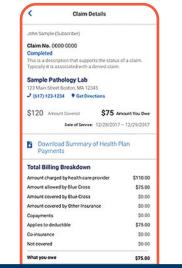
STAY ON TOP OF YOUR COVERAGE

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

YOUR PLAN IN YOUR HAND

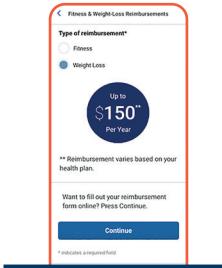


Once you sign in or create a MyBlue App account, you can see all of your benefits, all in one place. Track your claims, medications, account balances, and more from your device. And, you can easily keep track of reimbursements and savings.



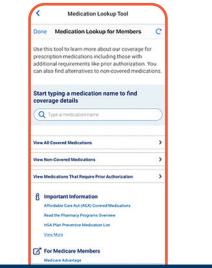
Track claims and benefits

Keep up to date on benefits and coverage.



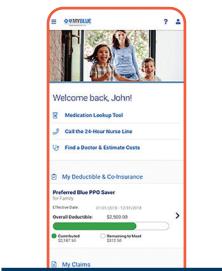
Fitness and weight-loss reimbursement

The online forms are here, along with other savings and offers.



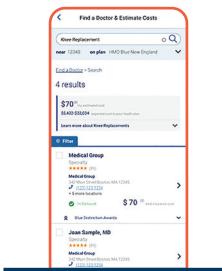
Your medications at a glance

Their names, costs, and prescriptions at your fingertips.



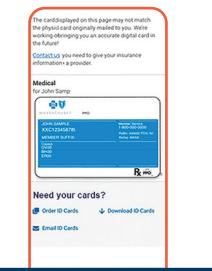
Check deductible balances

End the guesswork and know for sure every time.



Find a Doctor

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



Need your cards

Access your ID cards without opening your wallet.



GET THE MYBLUE APP

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

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WE SPECIALIZE IN MEDICAL CERTAINTY

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

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

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

WHO IS ELIGIBLE?

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

GET STARTED TODAY

Call at 1.866.841.2575

Visit www.2nd.MD/miia

or download our 2nd.MD app



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



HOW IT WORKS: 3 Simple Steps

1. ACTIVATE YOUR ACCOUNT AND REQUEST A CONSULT

Visit www.2nd.MD/miia, download our app or call us at 1.866.841.2575

2. SPEAK WITH A NURSE

Explain your medical issues and an experienced nurse will handle the rest, including collecting medical records and connecting you with a leading specialist who is an expert in your condition.

3. CONSULT WITH A LEADING SPECIALIST

Get information about your diagnosis, treatment plan and next steps in care from a nationally recognized specialist. Consult via video or phone at a time that works best for you, including evenings and weekends!

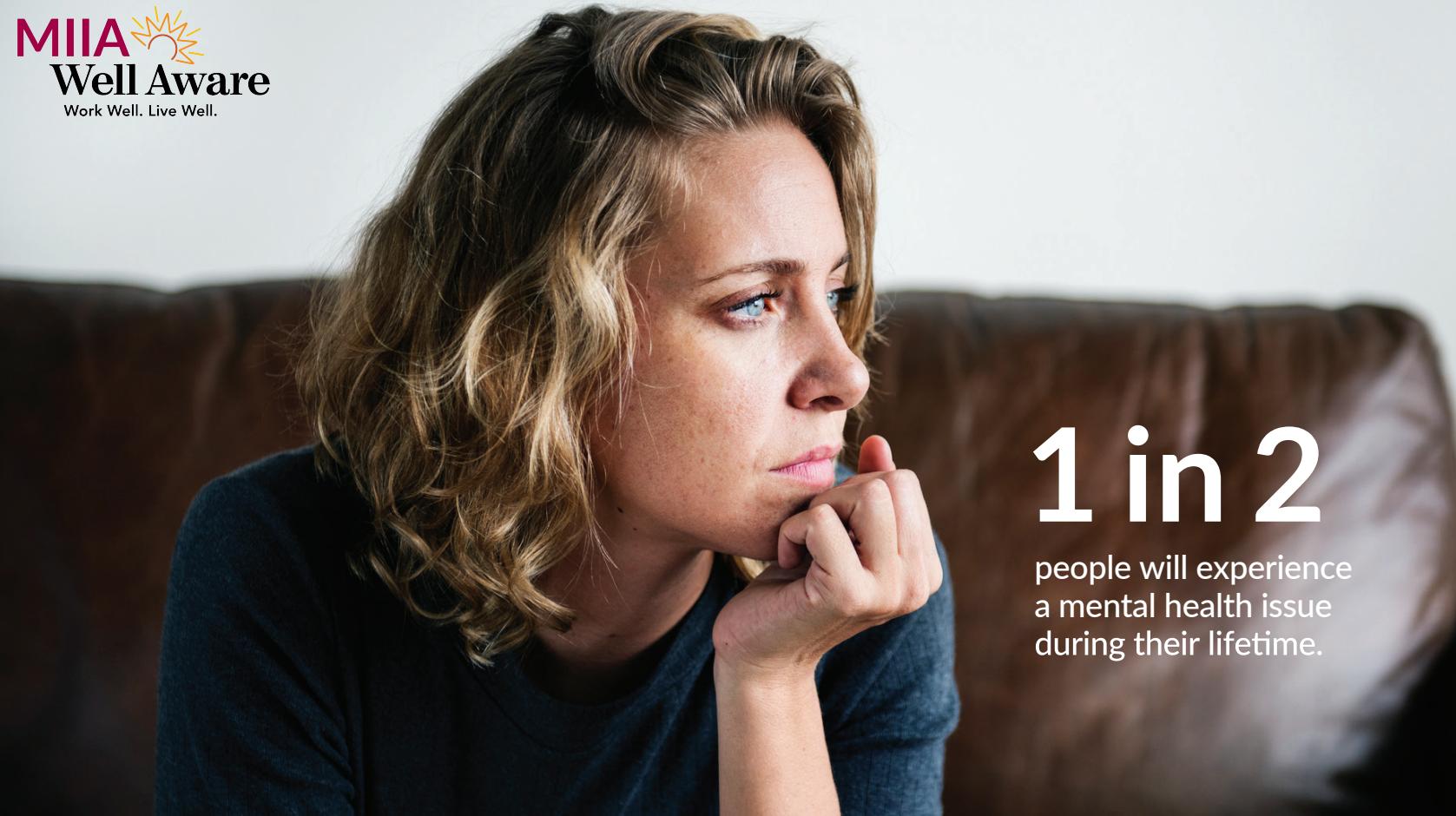
AFTER YOUR CONSULTATION

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

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



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1 in 2

people will experience
a mental health issue
during their lifetime.

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



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

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

Learn to Live benefits:

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

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

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

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

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

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A WHOLE NEW WAY TO DO PRIMARY CARE

Your Virtual Care Team is coming

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



PRIMARY CARE THAT'S A PRIME EXPERIENCE

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



CONVENIENT

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



COMPREHENSIVE

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



COORDINATED

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

SIGN UP TODAY!

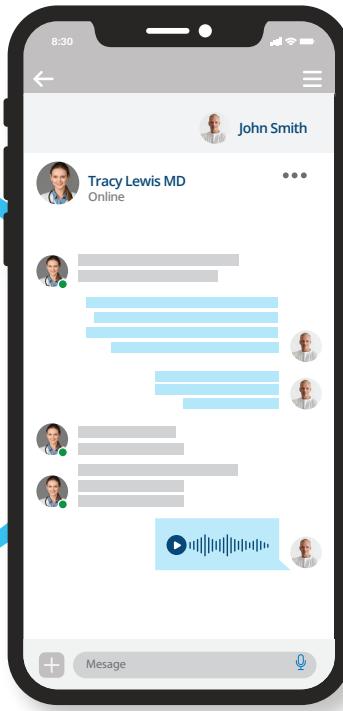
Log into your MyBlue account to get started.

HERE'S HOW IT WORKS

START BY PICKING
YOUR VIRTUAL PCP

ENJOY MORE
CONVENIENT CARE

GET THE BEST
OF BOTH WORLDS



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

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

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

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SUPPORT FOR YOUR MATERNITY JOURNEY

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



Maternity Care Management

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



Lactation Consultations

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



24/7 Nurse Line

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



Breast Pump Savings

Easily compare pump features to find the one that's right for you. Many are available at no cost and can be delivered right to your door. Learn more at bluecrossma.com/breast-pump.



Childbirth Course Reimbursement

Expectant mothers may be eligible for reimbursement up to \$90 for completing a childbirth course. Learn more at bcbsma.info/childbirthcourse.



Maternal Mental Health Support

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

Learn More

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

MYBLUE IS HERE TO HELP

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



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



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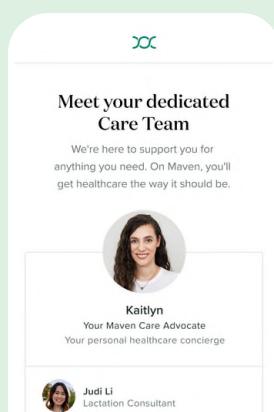
Meet Maven. Free virtual support for family building, pregnancy, parenting, and menopause.

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

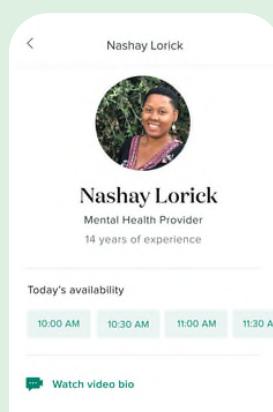


Here's what you and your partner get with Maven:

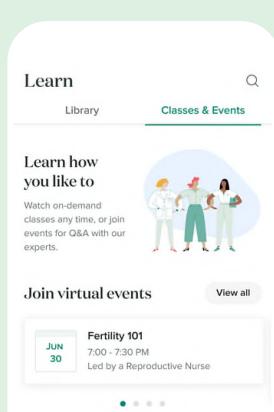
24/7 personalized support from a dedicated Care Advocate



Virtual appointments and messaging with specialists—anytime day or night



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



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



From starting a family

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



to having a child

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



to navigating parenthood

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



to managing all stages of menopause

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



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

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

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MASSACHUSETTS

DENTAL BLUE® ENHANCED DENTAL BENEFITS

Additional Support for Members with Qualifying Conditions

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

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

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

2. Self-enrollment is required for this condition. You can download the Enhanced Dental Benefits Enrollment Form at bluecrossma.org/myblue/fast-forms

3. Intellectual and/or Developmental Disabilities and Mental Health Conditions are being added to benefits on renewal starting October 1, 2023.

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

USING THESE BENEFITS

There's No Additional Cost to Receive These Extra Services⁴

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

Accessing Enhanced Dental Benefits

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

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

4. Qualifying members only.

Questions?

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

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).



MASSACHUSETTS

ENHANCED DENTAL BENEFITS ENROLLMENT FORM

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

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

Please check qualifying medical conditions:

Diabetes Coronary artery disease Stroke Pregnancy (expected date of birth ____/____/____)
 Oral cancer Sjögren's syndrome Intellectual and/or developmental disabilities* Mental health conditions*

Subscriber/Member Information

Subscriber Name	Member Name	Date of Birth ____/____/____	
Member Address	City	State	ZIP Code
Member Telephone # (Home)	Member Telephone # (Other)		

Blue Cross Blue Shield of Massachusetts Dental ID #

To Be Completed By Your Doctor

I hereby confirm that my patient has been diagnosed with the conditions listed above.

Doctor's Signature

Date
____/____/____

Doctor's Name (please print, circle MD or DO) MD/DO	License #	State
Doctor's Address	Doctor's Telephone #	

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

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

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

Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross and Blue Shield Association.

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MASSACHUSETTS

BLUE 20/20

LITTLE EYES, BIG BENEFITS

Vision coverage for kids under 19

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



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

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

SAVINGS AND DISCOUNTS

40% off
replacement glasses from
in-network locations

25% off
non-prescription
blue-light glasses

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

WHAT YOU NEED TO KNOW



Benefits will be applied to
your plan automatically



Applies to in-network
vision providers



At no additional cost
to you

Learn more

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



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

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

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

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

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MASSACHUSETTS

YOUR URGENT CARE OPTIONS



24/7 NURSE LINE

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

Cost:

Time:

Severity:



WELL CONNECTION

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

Cost:

Time:

Severity:



DOCTOR'S OFFICE

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

Cost:

Time:

Severity:



LIMITED SERVICE CLINICS

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

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.

Cost:

Time:

Severity:



EMERGENCY ROOM

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

Cost:

Time:

Severity:

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

1. Telehealth copays are waived for in-network visits, excluding those on the Saver Plan who have not yet met the annual deductible.
2. Medical services are available 24/7. Mental health visits must be made by appointment. If your local doctor in the Blue Cross Blue Shield of Massachusetts network offers covered services using live video visits through a service other than Well Connection, you're still covered. This service is available in the United States only.

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FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

\$300



Qualified for Reimbursement:

- A full-service health club with cardiovascular and strength-training equipment like treadmills, bikes, weight machines, and free weights
- A fitness studio with instructor-led group classes such as yoga, Pilates, Zumba®, kickboxing, indoor cycling/spinning, and other exercise programs
- Online fitness memberships, subscriptions, programs, or classes
- Cardiovascular and strength-training equipment for fitness that is purchased for use in the home, such as stationary bikes, weights, exercise bands, treadmills, fitness machines
- Athletic shoes – Shoes designed to be worn for sports, exercising, or recreational activity. Categories: running/training/walking, court sports, field sports, outdoor sports, track and field, and specialty shoes (i.e., gymnastics, weightlifting, etc.)
- Sports/Activity Fees – Ski passes, adult/child league sports fees (including town sports, tennis, etc.), race participation fees (5K, marathons, etc.)
- Bicycles/Bicycle Helmets- recreational bicycles and bicycle helmets



Not Qualified for Reimbursement:

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

GET STARTED!

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

Your reimbursement is waiting!

FITNESS REIMBURSEMENT REQUEST

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

Subscriber Information (Policyholder)			
Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial
Address – Number and Street	City	State	ZIP Code
Employer's Name			
Claim Information			
Member's Last Name	First Name	Middle Initial	Date of Birth ____/____/____
Claim is for (choose one and color in the entire box): <input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Spouse (of policyholder) <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Dependent (up to age 26) <input type="checkbox"/> Other (specify): _____	Name, Address, and Phone Number of Qualified Fitness Expense Total Dollars requested for Qualified Fitness Expense: \$ _____ Calendar year that fees were paid: _____		
Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.			
Certification and Authorization (This form must be signed and dated below.) I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these services. I enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to Blue Cross Blue Shield of Massachusetts.		Subscriber's or Member's Signature: _____ Date: ____/____/____	
Complete this form and mail it to: Blue Cross Blue Shield of Massachusetts, Local Claims Department, PO Box 986030, Boston, MA 02298			

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

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

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

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

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

1

Choose

Start by picking a qualified weight-loss program.

2

Complete

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

3

Mail

Send the completed form to the address listed.

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

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

Questions?

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

WEIGHT-LOSS REIMBURSEMENT REQUEST

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

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

Subscriber Information (Policyholder)			
Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial
Address - Number and Street	City	State	Zip Code
Employer's Name			
Claim Information			
Member Last Name	First Name	Middle Initial	Gender (color in the entire box) <input type="checkbox"/> Male <input type="checkbox"/> Female
Claim is for (choose one and color in the entire box):		Name, Address, and Phone Number of Qualified Weight-Loss Program	
<input type="checkbox"/> Subscriber (policyholder)	Total dollars requested: \$ _____		
<input type="checkbox"/> Spouse (of policyholder)	Monthly program participation fee: \$ _____		
<input type="checkbox"/> Ex-Spouse	Calendar Year: ____/____/____		
<input type="checkbox"/> Dependent (up to age 26)			
<input type="checkbox"/> Other (specify): _____			
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.			Date: ____/____/____
Subscriber's or Member's Signature:			
Important Information: <ul style="list-style-type: none">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:<ul style="list-style-type: none">Receipts (cash/check/credit/electronic) for participation fees clearly documenting your name, the weight-loss program name, and individual amounts charged with date paid.Your weight-loss program membership or participation agreement clearly documenting your name and date of enrollment/participation.Your reimbursement may be considered taxable income, so consult a tax advisor.			
Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.			
ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711). ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).			



MIND AND BODY REIMBURSEMENT

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

Save up to

\$300

per family per calendar year.



Qualified for Mind and Body Reimbursement:^{*}

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



Not Qualified for Mind and Body Reimbursement:

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

Find a Qualified Provider and Save

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

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

GET REIMBURSED IN THREE EASY STEPS

1

Choose

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

2

Complete

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

3

Mail

Send the completed form to the address listed.

Questions?

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

MIND AND BODY REIMBURSEMENT REQUEST

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

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

Subscriber Information (Policyholder)			
Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial
Address — Number and Street	City	State	ZIP Code
Employer's Name			
Claim Information			
Member's Last Name	First Name	Middle Initial	Date of Birth ____/____/____
Claim is for (choose one and color in the entire box):		Name, Address, and Phone Number for Qualified Expense (Service or App)	
<input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Spouse (of policyholder) <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Dependent (up to age 26) <input type="checkbox"/> Other (specify): _____		Total dollars requested: \$ _____	
Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.			
Certification and Authorization (This form must be signed and dated below.) I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these services. I enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to Blue Cross Blue Shield of Massachusetts.			
Subscriber's or Member's Signature:		Date: ____/____/____	

Important Information:

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

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

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

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

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

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

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

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

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

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

Complaint forms are available at hhs.gov.

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PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

Arabic/عَرَبِيَّة:

انتبه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النبوي للصم والبكم "TTY" : **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការដ្ឋានដំណឹង៖ ប្រសិនបើអ្នកនឹងយាយភាសា ខ្មែរ
សេវាដំនឹងយាយភាសាតំនើត តើអាជីវកម្មនសម្រាប់អ្នក។ សូមទូរសព្ទទៅអ្នកសេវាសមាជិកតាមលេខ
នៅលើប័ណ្ណសម្រាប់ខ្លួនរបស់អ្នក (TTY: **711**)។

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

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

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

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

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

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

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

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

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

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

Persian/پارسیان:

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

Lao/ລາວ: ຂໍ້ຄວບໄຟ້ໄຈ: ຖ້າຈົ່າເວົ້າພາວາວໄດ້, ມີການບໍລິການຈ່ວຍເຫຼືອດ້ານພາວາໃຫ້ທ່ານໂດຍ ບໍ່ແລ້ວຄ່າ. ໂທ້າຝ່າຍບໍລິການນະມາຊີກທີ່ໝາຍເວັກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áajíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíijí' béis̄h bee hodíílnih (TTY: 711).