**MEMORANDUM OF AGREEMENT**
**BETWEEN**
**THE TOWN OF BOXFORD**
**AND**
**THE M.G.L. c. 32B, §§ 21/23 BOXFORD PUBLIC EMPLOYEE COMMITTEE**
**TO PROVIDE HEALTH INSURANCE PURSUANT TO M.G.L. c. 32B, §§ 21/22**

**WHEREAS,** the Town of Boxford ("Town"), currently provides health insurance benefits directly through the Massachusetts Interlocal Insurance Association (MIIA), with plans offered by Blue Cross and Blue Shield of MA to its subscribers pursuant to M.G.L c. 32B, but not including M.G.L. c. 32B, §§21-22; and

**WHEREAS,** the Town, by a vote of its Select Board on January 22, 2024, elected to change health insurance benefits under M.G.L. c. 32B, §§ 21-23, as amended by Chapter 69 of the Acts of 2011, for the purpose of implementing changes in health insurance benefits it provides to its subscribers pursuant to M.G.L. c. 32B, §22;

**WHEREAS,** the Town thereafter requested the formation of a Public Employee Committee ("PEC") pursuant to 801 CMR 52.02;

**WHEREAS,** a PEC was formed and the Town delivered its 801 CMR 52.03 notice to the PEC representatives and;

**WHEREAS,** both the Town, through its Town Administrator, and the Public Employee Committee ("PEC") engaged in negotiations in good faith and, as a result of those negotiations, are entering into this written agreement effective July 1, 2024;

**NOW THEREFORE,** the Town and the PEC agree as follows:

## Effective Date of Agreement

1. This Agreement shall take effect on the date the Town and the PEC execute the Agreement.

## Purpose of Agreement

2. The purpose of this Agreement is to implement changes in health insurance benefits pursuant to M.G.L. c. 32B, § 22; health insurance plans will be offered through the Massachusetts Municipal Insurance Association (MIIA) Health Benefits Trust.

## Approval of MOA as PEC Agreement by the Town and the PEC

3. By executing this Agreement both the Town and the PEC agree to all of the terms of this Agreement.

4. It is further agreed that the provisions of this Agreement shall supersede any contrary provisions in any collective bargaining agreement and that all references to co-payments or other cost-sharing features in all collective bargaining agreements (whether executed before or after the ratification of this Agreement) shall be null and void and shall be considered physically removed from such collective bargaining agreements, effective July 1, 2024.

## Health Insurance Plans and Contributions

5. The following health insurance plans and contributions will be offered under this agreement;

- Network Blue New England $500 Deductible with HCCS
- Network Blue Select $500 Deductible
- Blue Care Elect $500 Deductible with HCCS
- Medex 2 w/PDP Option 26

Details of the benefit plans are incorporated into the Agreement as Attachment A.

## Notification

6. Subscribers shall be provided with at least 60 days advance notice of the plan design changes.

## Mitigation Plan

7. The Town will place 25% of the first-year projected savings into a mitigation fund. From this fund, the Town will provide a mitigation reimbursement in the form of a premium holiday. The amount of the premium holiday, as well as when it will be provided, will be determined once the final savings is determined

## Severability Clause

8. If any provision or portion of this Agreement is found to be unenforceable or unlawful, the remaining provisions or portions shall remain binding.

## Scope and Modification

9. This Agreement shall constitute the whole of the Agreement between the Town and the PEC. The Agreement may be modified only by a written agreement approved in the same manner as the original Agreement.

## Authorization to Sign Agreement

10. The PEC signatories to this Agreement attest to the fact that they are the duly authorized representatives of their respective collective bargaining unit appointed pursuant to the provision of M.G.L. c. 32B, § 21 and affirm that the plan design process has been initiated and fully completed pursuant to M.G.L. c. 32B §§ 21-22 and 801 CMR 52.00. Each signatory to this Agreement is authorized to bind the entity they represent. The PEC represents that is has the authorization and approval of a majority of the weighted voted of the PEC and that this Agreement is binding on all subscribers and their representative.

Date: _____

The Town of Boxford by its Select Board:

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Public Employee Committee:

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Maureen Cronin, Boxford Teachers' Association

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Ashley Cummings, Boxford Teachers' Association

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Myron Ricker, AFSCME Local 939 Boxford Public Works Employees

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Paula Spanos, AFSCME Local 939 Boxford Clerical/ Library Employees

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A.J. Paglia, Teamsters Local 25 Boxford Police Patrol Officers

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Tyler Brown, IAFF Local 5305 Boxford Firefighters Association

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Andrew Jakubasz, Boxford Communications Dispatchers Association

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Judith Durkee, Retired State, County and Municipal Employees Association of Massachusetts

Date: _____

The Town of Boxford by its Select Board:

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Public Employee Committee:

Maureen Cronin

Maureen Cronin, Boxford Teachers' Association

Ashley Cummings

Ashley Cummings, Boxford Teachers' Association

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Myron Ricker, AFSCME Local 939 Boxford Public Works Employees

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Public Employee Committee:

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Ashley Cummings, Boxford Teachers' Association

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Paula Spanos

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A.J. Paglia, Teamsters Local 25 Boxford Police Patrol Officers

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Tyler Brown, IAFF Local 5305 Boxford Firefighters Association

ANDREW S. JAKUBASZ

Andrew Jakubasz, Boxford Communications Dispatchers Association

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Judith Durkee, Retired State, County and Municipal Employees Association of Massachusetts

Date: 3/20/2024

The Town of Boxford by its Select Board:

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Public Employee Committee:

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Ashley Cummings, Boxford Teachers' Association

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Tyler Brown, IAFF Local 5305 Boxford Firefighters Association

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Andrew Jakubasz, Boxford Communications Dispatchers Association

Judith Durkee

Judith Durkee, Retired State, County and Municipal Employees Association of Massachusetts

# TOWN OF BOXFORD - FY 25 - ACTUAL RENEWAL

| Plan Name | Enrollment | I/F | # of Months | Rate | EMPLOYER Share | EMPLOYER Cost | EMPLOYEE Share | EMPLOYEE Cost | TOTAL Cost | ER % |
|---|---|---|---|---|---|---|---|---|---|---|
| NETWORK BLUE NE | 64 | I | 12 | 1058.12 | 835.91 | 641,983 | 222.21 | 170,654 | 812,636 | 79 |
| | 73 | F | 12 | 2826.88 | 1865.74 | 1,634,389 | 961.14 | 841,958 | 2,476,347 | 66 |
| | | **NETWORK BLUE TOTALS:** | | | | **2,276,372** | | **1,012,612** | **3,288,983** | |
| NETWORK BLUE NE | 2 | I | 12 | 952.31 | 752.32 | 18,056 | 199.99 | 4,800 | 22,855 | 79 |
| SELECT | 1 | F | 12 | 2544.19 | 1679.17 | 20,150 | 865.02 | 10,380 | 30,530 | 66 |
| | | **SELECT TOTALS:** | | | | **38,206** | | **15,180** | **53,386** | |
| BLUE CARE ELECT | 9 | I | 12 | 1250.80 | 988.13 | 106,718 | 262.67 | 28,368 | 135,086 | 79 |
| | 12 | F | 12 | 3346.82 | 2208.90 | 318,082 | 1137.92 | 163,860 | 481,942 | 66 |
| | | **BLUE CARE ELECT TOTALS:** | | | | **424,800** | | **192,228** | **617,028** | |
| MEDEX | 45 | I | 6 | 392.48 | 196.24 | 52,985 | 196.24 | 52,985 | 105,970 | 50 |
| | 45 | I | 6 | 416.97 | 208.49 | 56,291 | 208.49 | 56,291 | 112,582 | 50 |
| | | **MEDEX TOTALS:** | | | | **109,276** | | **109,276** | **218,552** | |
| MANAGED BLUE | 101 | I | 6 | 342.00 | 225.72 | 136,786 | 116.28 | 70,466 | 207,252 | 66 |
| FOR SENIORS | 101 | I | 6 | 356.98 | 235.61 | 142,778 | 121.37 | 73,552 | 216,330 | 66 |
| | | **MGD BLUE TOTALS:** | | | | **279,564** | | **144,018** | **423,582** | |
| | | | | **Budget Totals:** | | **3,128,217** | | **1,473,314** | **4,601,531** | |

# MIIA - $500/$1,000 DEDUCTIBLE

| Plan Name | Enrollment | I/F | # of Months | Rate | EMPLOYER Share | EMPLOYER Cost | EMPLOYEE Share | EMPLOYEE Cost | TOTAL Cost | ER % |
|---|---|---|---|---|---|---|---|---|---|---|
| NETWORK BLUE NE | 64 | I | 12 | 1004.16 | 793.29 | 609,244 | 210.87 | 161,951 | 771,195 | 79 |
| | 73 | F | 12 | 2682.71 | 1770.59 | 1,551,036 | 912.12 | 799,018 | 2,350,054 | 66 |
| | | **NETWORK BLUE TOTALS:** | | | | **2,160,280** | | **960,969** | **3,121,249** | |
| NETWORK BLUE NE | 2 | I | 12 | 873.62 | 690.16 | 16,564 | 183.46 | 4,403 | 20,967 | 79 |
| SELECT | 1 | F | 12 | 2333.96 | 1540.41 | 18,485 | 793.55 | 9,523 | 28,008 | 66 |
| | | **SELECT TOTALS:** | | | | **35,049** | | **13,926** | **48,974** | |
| BLUE CARE ELECT | 9 | I | 12 | 1189.51 | 939.71 | 101,489 | 249.80 | 26,978 | 128,467 | 79 |
| | 12 | F | 12 | 3182.82 | 2100.66 | 302,495 | 1082.16 | 155,831 | 458,326 | 66 |
| | | **BLUE CARE ELECT TOTALS:** | | | | **403,984** | | **182,809** | **586,793** | |
| MEDEX | 45 | I | 6 | 392.48 | 196.24 | 52,985 | 196.24 | 52,985 | 105,970 | 50 |
| | 45 | I | 6 | 416.97 | 208.49 | 56,291 | 208.49 | 56,291 | 112,582 | 50 |
| | | **MEDEX TOTALS:** | | | | **109,276** | | **109,276** | **218,552** | |
| MANAGED BLUE | 101 | I | 6 | 342.00 | 225.72 | 136,786 | 116.28 | 70,466 | 207,252 | 66 |
| FOR SENIORS | 101 | I | 6 | 356.98 | 235.61 | 142,778 | 121.37 | 73,552 | 216,330 | 66 |
| | | **MGD BLUE TOTALS:** | | | | **279,564** | | **144,018** | **423,582** | |
| | | | | **Budget Totals:** | | **2,988,152** | | **1,410,997** | **4,399,150** | |
| | | | | **Difference:** | | **(140,065)** | | **(62,316)** | **(202,381)** | |
| | | | | **Mitigation:** | | **50,595** | | | | |
| | | | | **Net Savings:** | | **(89,470)** | | | | |

BlueCross® BlueShield®

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

SUMMARY OF BENEFITS

# NETWORK BLUE® NEW ENGLAND $500 DEDUCTIBLE

## WITH HOSPITAL CHOICE COST SHARING

MIIA Benchmark 3

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


## UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

**Sign in**

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

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

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

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

# YOUR CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Covered Services | Your Cost |
|---|---|
| **Preventive Care** | |
| Well-child care exams | Nothing, no deductible |
| Routine adult physical exams, including related tests | Nothing, no deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | Nothing, no deductible |
| Routine hearing exams, including routine tests | Nothing, no deductible |
| Hearing aids (up to $5,000 per ear every 36 months) | All charges beyond the maximum, no deductible |
| Routine vision exams (one every 24 months) | Nothing, no deductible |
| Family planning services—office visits | Nothing, no deductible |
| **Outpatient Care** | |
| Emergency room visits | $100 per visit after deductible<br>(copayment waived if admitted or for observation stay) |
| Office or health center visits, when performed by:<br>• Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care<br>• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | $20 per visit, no deductible<br>$60 per visit, no deductible |
| Mental health or substance use treatment | $10 per visit, no deductible |
| Outpatient telehealth services<br>• With a covered provider<br>• With the designated telehealth vendor for simple medical conditions<br>• With the designated telehealth vendor for mental health services | Same as in-person visit<br>$20 per visit, no deductible<br>$10 per visit, no deductible |
| Chiropractors' office visits (up to 20 visits per calendar year) | $20 per visit, no deductible |
| Acupuncture visits (up to 12 visits per calendar year) | $60 per visit, no deductible |
| Short-term rehabilitation therapy—physical and occupational<br>(up to 30 visits per calendar year for each type of therapy*) | $20 per visit, no deductible |
| Speech, hearing, and language disorder treatment—speech therapy | $20 per visit, no deductible |
| Diagnostic X-rays and lab tests | Nothing after deductible |
| CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | $100 per category per service date after deductible |
| Home health care and hospice services | Nothing after deductible |
| Oxygen and equipment for its administration | Nothing after deductible |
| Durable medical equipment—such as wheelchairs, crutches, hospital beds | Nothing after deductible** |
| Prosthetic devices | Nothing after deductible |
| Surgery and related anesthesia in an office or health center, when performed by:<br>• Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care<br>• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | $20 per visit***, no deductible<br>$60 per visit***, no deductible |
| Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit | $250 per admission after deductible |
| **Inpatient Care (including maternity care) in:** | |
| • Other general hospitals (as many days as medically necessary)<br>• Higher cost share hospitals (as many days as medically necessary) | $275 per admission after deductible†<br>$1,500 per admission after deductible† |
| Chronic disease hospital care (as many days as medically necessary) | Nothing after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | $275 per admission, no deductible |
| Rehabilitation hospital care (as many days as medically necessary) | Nothing after deductible |
| Skilled nursing facility care (up to 45 days per calendar year) | 20% coinsurance after deductible |

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital.

| Covered Services | Your Cost |
|---|---|
| **Prescription Drug Benefits*** | |
| At designated retail pharmacies<br>(up to a 30-day formulary supply for each prescription or refill)** | $10 after deductible for Tier 1<br>$30 after deductible for Tier 2<br>$65 after deductible for Tier 3 |
| Through the designated mail order or designated retail pharmacy<br>(up to a 90-day formulary supply for each prescription or refill)** | $25 after deductible for Tier 1<br>$75 after deductible for Tier 2<br>$165 after deductible for Tier 3 |

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived 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**<br>Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.) | $300 per calendar year per policy |
| Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.) | $300 per calendar year per policy |

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

## QUESTIONS?

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

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



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MASSACHUSETTS

# NONDISCRIMINATION NOTICE

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

## BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

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

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

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

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

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

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


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# PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

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

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

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


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55-1493 (6/21)

MASSACHUSETTS

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

SUMMARY OF BENEFITS

# NETWORK BLUE® SELECT $500 DEDUCTIBLE

MIIA Benchmark 3

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


## UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

**Sign in**

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

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

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

# YOUR CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

| Covered Services | Your Cost |
|---|---|
| **Preventive Care** | |
| Well-child care exams | Nothing, no deductible |
| Routine adult physical exams, including related tests | Nothing, no deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | Nothing, no deductible |
| Routine hearing exams, including routine tests | Nothing, no deductible |
| Hearing aids (up to $5,000 per ear every 36 months) | All charges beyond the maximum, no deductible |
| Routine vision exams (one every 24 months) | Nothing, no deductible |
| Family planning services—office visits | Nothing, no deductible |
| **Outpatient Care** | |
| Emergency room visits | $100 per visit after deductible<br>(copayment waived if admitted or for observation stay) |
| Office or health center visits, when performed by:<br>• Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care<br>• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | $20 per visit, no deductible<br>$60 per visit, no deductible |
| Mental health or substance use treatment | $10 per visit, no deductible |
| Outpatient telehealth services<br>• With a covered provider<br>• With the designated telehealth vendor for simple medical conditions<br>• With the designated telehealth vendor for mental health services | Same as in-person visit<br>$20 per visit, no deductible<br>$10 per visit, no deductible |
| Chiropractors' office visits (up to 20 visits per calendar year) | $20 per visit, no deductible |
| Acupuncture visits (up to 12 visits per calendar year) | $60 per visit, no deductible |
| Short-term rehabilitation therapy—physical and occupational<br>(up to 30 visits per calendar year for each type of therapy*) | $20 per visit, no deductible |
| Speech, hearing, and language disorder treatment—speech therapy | $20 per visit, no deductible |
| Diagnostic X-rays and lab tests | Nothing after deductible |
| CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | $100 per category per service date after deductible |
| Home health care and hospice services | Nothing after deductible |
| Oxygen and equipment for its administration | Nothing after deductible |
| Durable medical equipment—such as wheelchairs, crutches, hospital beds | Nothing after deductible** |
| Prosthetic devices | Nothing after deductible |
| Surgery and related anesthesia in an office or health center, when performed by:<br>• Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care<br>• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | $20 per visit***, no deductible<br>$60 per visit***, no deductible |
| Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit | $250 per admission after deductible |
| **Inpatient Care (including maternity care)** | |
| General hospital care (as many days as medically necessary) | $275 per admission after deductible† |
| Chronic disease hospital care (as many days as medically necessary) | Nothing after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | $275 per admission, no deductible |
| Rehabilitation hospital care (as many days as medically necessary) | Nothing after deductible |
| Skilled nursing facility care (up to 45 days per calendar year) | 20% coinsurance after deductible |

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital.

| Covered Services | Your Cost |
|---|---|
| **Prescription Drug Benefits*** | |
| At designated retail pharmacies<br>(up to a 30-day formulary supply for each prescription or refill)** | $10 after deductible for Tier 1<br>$30 after deductible for Tier 2<br>$65 after deductible for Tier 3 |
| Through the designated mail order or designated retail pharmacy<br>(up to a 90-day formulary supply for each prescription or refill)** | $25 after deductible for Tier 1<br>$75 after deductible for Tier 2<br>$165 after deductible for Tier 3 |

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived 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**<br>Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.) | $300 per calendar year per policy |
| Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.) | $300 per calendar year per policy |

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

## QUESTIONS?

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

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



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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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55-1487 (6/21)

# 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**).

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

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

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

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

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

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

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


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55-1493 (6/21)

BlueCross® BlueShield®

**SUMMARY OF BENEFITS**

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

# Blue Care® Elect $500 Deductible

with Hospital Choice Cost Sharing

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

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

**MyBlue is a personalized way to access and manage your health plan.** Get secure access to key plan information, claims history, and recent medications. Download or email a copy of your digital ID card. View your spending dashboard, important updates, alerts and notifications. Register or log in at bluecrossma.com/myblue or download the app on iTunes® or Google Play™.

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

# Your Choice

## Your Deductible

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

## When You Choose Preferred Providers

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

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

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

## Higher Cost Share Hospitals

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

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

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

## How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider in the Provider Directory. 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.com/findadoctor**

## When You Choose Non-Preferred Providers

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

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

## Your Out-of-Pocket Maximum

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

## Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your in-network deductible, you pay a copayment per visit for in-network or out-of-network emergency room services. 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

You are covered for certain medical and mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at **wellconnection.com** on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com**, consult the Provider Directory, or call the Member Service number on your ID card.

## Utilization Review Requirements

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

## 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.

# Your Medical Benefits

| Covered Services | Your Cost In-Network | Your Cost Out-of-Network |
|---|---|---|
| **Preventive Care**<br>Well-child care exams, including routine tests, according to age-based schedule as follows:<br>• 10 visits during the first year of life<br>• Three visits during the second year of life (age 1 to age 2)<br>• Two visits for age 2<br>• One visit per calendar year for age 3 and older | Nothing, no deductible | 20% coinsurance after deductible |
| Routine adult physical exams, including related tests (one per calendar year) | Nothing, no deductible | 20% coinsurance after deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | Nothing, no deductible | 20% coinsurance after deductible |
| Routine hearing exams, including related tests | Nothing, no deductible | 20% coinsurance after deductible |
| Hearing aids (up to $5,000 per ear every 36 months) | All charges beyond the maximum, no deductible | 20% coinsurance after deductible and all charges beyond the maximum |
| Routine vision exams (one every 24 months) | Nothing, no deductible | 20% coinsurance after deductible |
| Family planning services–office visits | Nothing, no deductible | 20% coinsurance after deductible |
| **Outpatient Care**<br>Emergency room visits | $100 per visit after deductible (copayment waived if admitted or for observation stay) | $100 per visit after in-network deductible (copayment waived if admitted or for observation stay) |
| Office or health center visits, when performed by:<br>• A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, licensed dietitian nutritionist, optometrist, or by a physician assistant or nurse practitioner designated as primary care<br>• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | $20 per visit, no deductible<br>$60 per visit, no deductible | 20% coinsurance after deductible<br>20% coinsurance after deductible |
| Mental health or substance use treatment | $10 per visit, no deductible | 20% coinsurance after deductible |
| Telehealth services<br>• Simple medical conditions<br>• Mental health services | $20 per visit, no deductible<br>$10 per visit, no deductible | 20% coinsurance after deductible<br>20% coinsurance after deductible |
| Chiropractors' office visits (up to 20 visits per calendar year) | $20 per visit, no deductible | 20% coinsurance after deductible |
| Acupuncture visits (up to 12 visits per calendar year) | $60 per visit, no deductible | 20% coinsurance after deductible |
| Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*) | $20 per visit, no deductible | 20% coinsurance after deductible |
| Speech, hearing, and language disorder treatment–speech therapy | $20 per visit, no deductible | 20% coinsurance after deductible |
| Diagnostic X-rays and lab tests | Nothing after deductible | 20% coinsurance after deductible |
| CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | $100 per category per service date after deductible | 20% coinsurance after deductible |
| Home health care and hospice services | Nothing after deductible | 20% coinsurance after deductible |
| Oxygen and equipment for its administration | Nothing after deductible | 20% coinsurance after deductible |
| Durable medical equipment such as wheelchairs, crutches, hospital beds | Nothing after deductible** | 20% coinsurance after deductible |
| Prosthetic devices | Nothing after deductible | 20% coinsurance after deductible |
| Surgery and related anesthesia in an office or health center, when performed by:<br>• A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care<br>• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | $20 per visit***, no deductible<br>$60 per visit***, no deductible | 20% coinsurance after deductible<br>20% coinsurance after deductible |
| Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit | $250 per admission 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.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

| Covered Services | Your Cost In-Network | Your Cost Out-of-Network |
|---|---|---|
| **Inpatient Care (including maternity care) in:** | | |
| • Other general hospitals (as many days as medically necessary) | $275 per admission after deductible* | 20% coinsurance after deductible |
| • Higher cost share hospitals (as many days as medically necessary) | $1,500 per admission after deductible* | 20% coinsurance after deductible |
| Chronic disease hospital care (as many days as medically necessary) | Nothing after deductible | 20% coinsurance after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | $275 per admission, no deductible | 20% coinsurance after deductible |
| Rehabilitation hospital care (as many days as medically necessary) | Nothing after deductible | 20% coinsurance after deductible |
| Skilled nursing facility care (up to 45 days per calendar year) | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Prescription Drug Benefits**** | | |
| At designated retail pharmacies*** (up to a 30-day formulary supply for each prescription or refill)† | After deductible<br>$10 for Tier 1<br>$30 for Tier 2<br>$65 for Tier 3 | Not covered |
| Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)† | After deductible<br>$25 for Tier 1††<br>$75 for Tier 2<br>$165 for Tier 3 | Not covered |

* This cost share applies to mental health admissions in a general hospital.
** Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
*** Specialty drugs available only when obtained from a designated specialty pharmacy.
† Cost share may be waived for certain covered drugs and supplies.
†† Certain generic medications are available through the mail order pharmacy at $9. For more information, go to bluecrossma.com/mail-order-pharmacy.

## Get the Most from Your Plan

Visit us at **bluecrossma.com** 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**<br>**Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs**<br>This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs. (See your benefit description for details.) | $150 per calendar year per policy |
| **Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program**<br>This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.) | $150 per calendar year per policy |
| 24/7 Nurse Care Line—A 24-hour nurse line to answer your health care questions—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.com**.
Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at **bluecrossma.com/myblue**.

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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BlueCross® BlueShield®

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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MASSACHUSETTS

# Translation Resources
## Proficiency of Language Assistance Services

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

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

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

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

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

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

**Arabic/ةيبر:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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


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