TOWN OF BOXFORD

PROPOSAL

MUNICIPAL HEALTH REFORM LAW

UNDER CHAPTER 69 OF THE ACTS OF 2011

MGL. Chapter 32B, Sections 21-23

TOWN OF BOXFORD HEALTH PLAN PROPOSAL

Effective July 1, 2024

1. **Executive Summary**
2. **Proposed Mitigation**
3. **Current and Proposed Benefits Budget**
4. **Current Benefit Summaries**
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1. EXECUTIVE SUMMARY

Town of Boxford
Municipal Health Reform Law
Executive Summary

The Municipal Health Reform Law outlines the procedure for Massachusetts municipalities to either modify their plans up to the level of the Group Insurance Commission's (GIC) most popular plan design or to join the GIC plans directly. The following is the Town of Boxford's proposal effective July 1, 2024. We are not proposing to join the GIC, but rather to remain with MIIA.

You will note that our proposal is to modify benefits up to the current deductibles and copayments of the GIC Benchmark plan (HPHC Explorer) under the current HMO and PPO plans. There are no proposed changes to the Medicare supplement plan. The Town's proposed mitigation plan would share 25% of the total first year savings with our employees and non-Medicare retirees over and above the savings realized by reduced rates.

The first step in this process is to provide information to the Insurance Advisory Committee (IAC) and present an opportunity to meet and discuss this information. Under Mass. Gen. Laws Ch. 32B, § 21-23, the Town must meet with the IAC within 10 days of receipt of this package. This meeting will occur on February 7, 2024 at 3:30 pm at Town Hall.

After meeting with the IAC, a Public Employee Committee (PEC) will be formed and will include union representatives and a retiree representative. The PEC is the negotiating group. Notice will be provided to the members of the PEC, along with this comprehensive package of information regarding proposed health insurance changes.

Following receipt of the notice, the Town will meet with the PEC as often as necessary during the next thirty days to reach an agreement among all parties. Absent an agreement within thirty days, this proposal will be forwarded to a three-person panel that will review it for compliance and, if they agree with the proposal, they will instruct the Town to implement these changes.

We believe this proposal would reduce the total projected costs in the first twelve months after implementation by approximately $ 202,381. Therefore, based on these projected savings, the mitigation fund that would be set aside by the Town to offset the cost of the benefits for employees/non-Medicare retirees would be $50,595.

Respectfully Submitted,
The Town of Boxford

2. PROPOSED MITIGATION PLAN

The definition of the mitigation plan under 801 CMR 52:01 is as follows:

Mitigation Proposal: A proposal to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected.

The Town of Boxford proposes to put 25% of the total first year savings into a mitigation fund. This is projected to be approximately $50,595. The combination of employee contribution savings and mitigation funds provides the employees with 57% of the total first year savings.

The Town proposes to administer the mitigation fund by providing a premium holiday to all employees and non-Medicare retirees. The rationale is that this will provide funding to all employees and retirees to assist with the increased out-of-pocket costs.

3. CURRENT AND PROPOSED BUDGETS

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)**				

4. CURRENT BENEFIT SUMMARIES

BlueCross® BlueShield®

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

SUMMARY OF BENEFITS

BLUE CARE ELECT $250 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

MIIA Town of Boxford

Plan-Year Deductible: $250/$750

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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

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

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

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

YOUR CHOICE

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each 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 deductibles are **$250** per member (or **$750** per family) for in-network services and **$400** per member (or **$800** 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.

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

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

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

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

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

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

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

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

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

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

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

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

Your Virtual Care Team
Your health plan includes the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **For in-network outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For in-network outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your benefit description, or call the Member Service number on your ID card.

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

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

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for an observation stay)	$100 per visit after 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, licensed dietitian nutritionist, optometrist, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit, no deductible $35 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Mental health or substance use treatment	$15 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the in-network designated telehealth vendor for simple medical conditions • With the in-network designated telehealth vendor for mental health services	Same as in-person visit $20 per visit, no deductible $15 per visit, no deductible	Same as in-person visit Only applicable in-network Only applicable in-network
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)	$35 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit***, no deductible $35 per visit***, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care) in:		
• Other general hospitals (as many days as medically necessary) • In-network higher cost share hospitals (as many days as medically necessary)	$300 per admission after deductible† $700 per admission after deductible†	20% coinsurance after deductible Only applicable in-network
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)	$200 per admission after 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)	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.
** Cost share waived for one breast pump per birth, including supplies.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost 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 $50 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 $110 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 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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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 (6/22)

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

SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND $250 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

MIIA Town of Boxford

Plan-Year Deductible: $250/$750

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

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

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

YOUR CARE

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

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

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

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

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

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

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

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

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

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

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for 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 **$250** per member (or **$750** per family).

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and copayments 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.

Your Virtual Care Team
Your health plan includes the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **For outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your benefit description, or call the Member Service number on your ID card.

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

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

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

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit, no deductible $35 per visit, no deductible
Mental health or substance use treatment	$15 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor for simple medical conditions • With the designated telehealth vendor for mental health services	Same as in-person visit $20 per visit, no deductible $15 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)	$35 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit***, no deductible $35 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible
Inpatient Care (including maternity care) in:	
• Other general hospitals (as many days as medically necessary) • Higher cost share hospitals (as many days as medically necessary)	$300 per admission after deductible† $700 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)	$200 per admission after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 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.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible $10 for Tier 1 $25 for Tier 2 $50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible $20 for Tier 1 $50 for Tier 2 $110 for Tier 3

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived 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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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 (6/22)

MASSACHUSETTS

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

SUMMARY OF BENEFITS

NETWORK BLUE® SELECT $250 DEDUCTIBLE

MIIA Town of Boxford

Plan-Year Deductible: $250/$750

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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

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

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

YOUR CARE

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

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

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

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

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

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for 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 **$250** per member (or **$750** per family).

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

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

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

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

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

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

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit, no deductible $35 per visit, no deductible
Mental health or substance use treatment	$15 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor for simple medical conditions • With the designated telehealth vendor for mental health services	Same as in-person visit $20 per visit, no deductible $15 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)	$35 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit***, no deductible $35 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible
Inpatient Care (including maternity care)	
General hospital care (as many days as medically necessary)	$300 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)	$200 per admission after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 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.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible $10 for Tier 1 $25 for Tier 2 $50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible $20 for Tier 1 $50 for Tier 2 $110 for Tier 3

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived 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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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 (6/22)

5. PROPOSED BENEFIT CHANGES

		CURRENT	PROPOSED
Calendar Year Deductible	Individual Family	$250 $750	$500 $1,000
Out-of-Pocket Maximum	Individual Family	Medical/RX $2,500/1,000 $5,000/2,000	Medical/RX $2,500/1,000 $5,000/2,000
Primary Care Office Visit		$20	$20
Specialist Office Visit		$35	$60
Emergency Room		$100 after deductible	$100 after deductible
Hospital Admission	Tier 1 Tier 2	$300 $700 Select - $300 after deductible	$275 $1,500 Select - $275 after deductible
Hospital Outpatient Surgery		$150 after deductible	$250 after deductible
High Tech Imaging (MRI, CT, PET)		$100 after deductible	$100 after deductible
Prescriptions			$100/200 Deductible
Retail 30-day supply	Tier 1 Tier 2 Tier 3	$10 $25 $50	$10 $30 $65
Mail Order 90-day supply	Tier 1 Tier 2 Tier 3	$20 $50 $110	$25 $75 $165

* Blue Care Elect out-of-network deductible is $400/$800

For more detailed information please see attached benefit summaries.

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

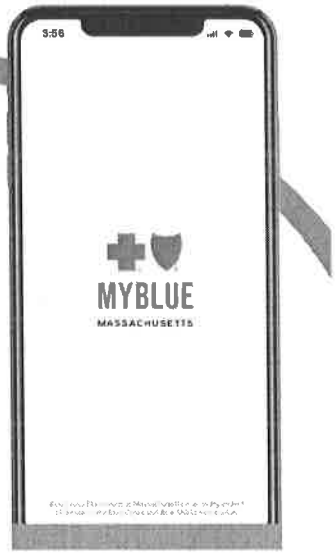
SUMMARY OF BENEFITS

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

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

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

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

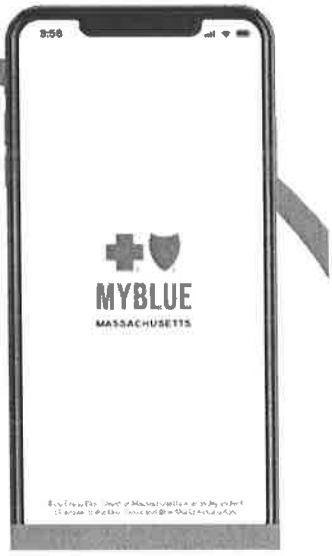
COVERAGE AND BENEFITS

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

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

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

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

SUMMARY OF BENEFITS

MIIA Massachusetts Interlocal Insurance Association

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 Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including 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 Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)	$100 per visit after in-network deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, licensed dietitian nutritionist, optometrist, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit, no deductible $60 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Mental health or substance use treatment	$10 per visit, no deductible	20% coinsurance after deductible
Telehealth services • Simple medical conditions • Mental health services	$20 per visit, no deductible $10 per visit, no deductible	20% coinsurance after deductible 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: • 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 • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit***, no deductible $60 per visit***, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Surgery 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) • Higher cost share hospitals (as many days as medically necessary)	 $275 per admission after deductible* $1,500 per admission after deductible*	 20% coinsurance after deductible 20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$275 per admission, no deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drug Benefits** At designated retail pharmacies*** (up to a 30-day formulary supply for each prescription or refill)†	 After deductible $10 for Tier 1 $30 for Tier 2 $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 $25 for Tier 1†† $75 for Tier 2 $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 **Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs** 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 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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6. **GIC BENEFIT SUMMARY**

(The Benchmark plan is Harvard Pilgrim Explorer)

Benefits-at-a-Glance (Non-Medicare)

HEALTH INSURANCE PLANS	NATIONAL NETWORK	BROAD NETWORK		
	HARVARD PILGRIM ACCESS AMERICA	UNICARE TOTAL CHOICE	UNICARE PLUS	HARVARD PILGRIM EXPLORER
GEOGRAPHIC ELIGIBILITY	U.S. Outside New England	New England	New England	New England
PLAN TYPE	PPO	INDEMNITY	PPO-TYPE	POS
PCP Designation Required?	No	No	No	Yes
PCP Referral to Specialist Required?	No	No	No	Yes
Out-of-pocket Maximum Individual coverage Family coverage	$5,000 $10,000	$5,000 $10,000	$5,000 $10,000	$5,000 $10,000
Fiscal Year Deductible Individual / Family	$500 / $1,000	$500 / $1,000	$500 / $1,000	$500 / $1,000
Primary Care Provider Office Visit	$20 / visit	$20 / visit	**Tier 1: $10 / visit** **Tier 2: $20 / visit** **Tier 3: $40 / visit**	Tier 1: $10 / visit Tier 2: $20 / visit Tier 3: $40 / visit
Preventive Services	Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay
Specialist Physician Office Visit Tier 1 / Tier 2 / Tier 3	$45 / visit (no tiering)	**$45 / visit (no tiering)**	$30 / $60 / $75 / visit	$30 / $60 / $75 / visit
Retail Clinic and Urgent Care Center	$20 / visit	$20 / visit	$20 / visit	$20 / visit
Outpatient Behavioral Health/ Substance Use Disorder Care	$20 / visit	**$20 / visit**	**$10 / visit**	$10 / visit
Emergency Room Care	$100 / visit (waived if admitted)	$100 / visit (waived if admitted)	$100 / visit (waived if admitted)	$100 / visit (waived if admitted)
Inpatient Hospital Care – Medical	Maximum one copay per person per calendar year quarter. Waived if readmitted within 30 days in the same calendar year.			
Tier 1 / Tier 2 / Tier 3	$275 / admission no tiering	$275 / admission no tiering	$275 / $500 / $1,500 / admission	$275 / $500 / $1,500 / admission
Outpatient Surgery				
Eye & GI procedures at freestanding facilities in Massachusetts	$150	**$150**	**$150**	$150
All other in Massachusetts	$250	**$250**	**$250**	$250
High-Tech Imaging	Maximum one copay per day. Contact the carrier for details.			
(e.g., MRI, CT & PET scans)	$100 / scan	$100 / scan	$100 / scan	$100 / scan
Prescription Drugs	Prescription Drug Deductible: $100 Individual / $200 Family			
Retail (up to a 30-day supply) Tier 1 / Tier 2 / Tier 3	$10 / $30 / $65	$10 / $30 / $65	$10 / $30 / $65	$10 / $30 / $65
Mail Order Maintenance Drugs (up to a 90-day supply) Tier 1 / Tier 2 / Tier 3	$25 / $75 / $165	$25 / $75 / $165	$25 / $75 / $165	$25 / $75 / $165

If you participate in a non-Medicare plan, GIC protects you from balance billing under Massachusetts General Law Chapter 32A, §20.

If you receive covered, medically necessary medical care *in Massachusetts*, doctors, hospitals, and other medical providers may only collect the amount covered by your GIC plan. You are still responsible for your share of the plan's copays, deductibles, and any other eligible medical out-of-pocket costs, but *not* any excess.

Always compare bills to the Explanation of Benefits (EOB) statement provided by your GIC health carrier. If you are not sure your invoice is a balance bill, call your health carrier. If it is a balance bill, advise your provider that as a GIC member, you are not liable for their excess compensation. If your provider persists in efforts to collect, contact the Group Insurance Commission.