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GET THE MOST OUT OF YOUR PLAN



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MEDICATION



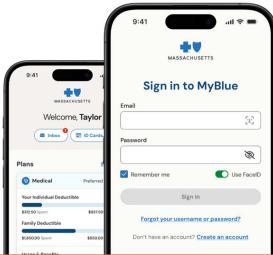
CONTACT US



SAVINGS
AND DEALS



UNDERSTANDING YOUR
PLAN AND BENEFITS



INTRODUCING THE NEW MYBLUE APP

The simplest way to tap into your health plan.

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

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NETWORK BLUE® NEW ENGLAND \$300 DEDUCTIBLE

MIIA Town of Boxborough

Plan-Year Deductible: \$300/\$900

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



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



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

YOUR CARE

Your Primary Care Provider (PCP)

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

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

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

Referrals

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

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

Your Deductible

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

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and copayments for covered services. Your out-of-pocket maximum for medical benefits is **\$2,000** per member (or **\$4,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$3,000** per member (or **\$6,000** per family).

Emergency Room Services

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

Telehealth Services

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

Your Virtual Care Team

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

Value Care Offering Coverage

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

Service Area

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

When Outside the Service Area

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

Dependent Benefits

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one every 12 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	\$20 per visit, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$45 per visit, no deductible
Mental health or substance use treatment	\$20 per visit, no deductible
Outpatient telehealth services	Same as in-person visit \$20 per visit, no deductible
• With a covered provider	
• With the designated telehealth vendor	
Chiropractors' office visits (up to 12 visits per calendar year)	\$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$45 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$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	\$20 per visit***, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$45 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$250 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission after deductible
Rehabilitation hospital care (up to 100 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

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

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

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

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

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

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

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

Wellness Participation Program

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

\$300 per calendar year per policy

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

\$300 per calendar year per policy

Mind and Body Wellness Program

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

\$300 per calendar year per policy

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

QUESTIONS?

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

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

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$300 member / \$900 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , prenatal care, <u>prescription drugs</u> , most office visits, mental health visits, therapy visits, emergency transportation.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, \$2,000 member / \$4,000 family; and for <u>prescription drug</u> benefits, \$3,000 member / \$6,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$45 / visit; \$20 / chiropractor visit; \$45 / acupuncture visit	Not covered	Limited to 12 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$100	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$25 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$30 / retail supply or \$75 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$65 / retail supply or \$165 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$20 / visit	\$20 / visit	Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable

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

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

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's [marketplace](#), if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Does this [plan](#) provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care [plan](#). It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$300
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$500
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

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

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

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

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$860

Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist visit copay</u>	\$45
■ <u>Primary care visit copay</u>	\$20
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

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

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

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist visit copay</u>	\$45
■ <u>Emergency room copay</u>	\$100
■ <u>Ambulance services copay</u>	\$0

This EXAMPLE event includes services like:

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

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

In this example, Mia would pay:

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

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$600

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

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MASSACHUSETTS

MCC COMPLIANCE



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

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NETWORK BLUE® SELECT SAVER

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

MIIA Town of Boxborough

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



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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 **\$2,000** per individual membership (or **\$4,000** per family membership). **The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.**

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and copayments for covered services. Your out-of-pocket maximum for medical and prescription drug benefits is **\$6,550** per member (or **\$13,100** per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay nothing for emergency room services.

Telehealth Services

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

Your Virtual Care Team

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

Service Area

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

When Outside the Service Area

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

Dependent Benefits

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

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

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

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

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

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

\$10 after deductible for Tier 1

\$30 after deductible for Tier 2

\$65 after deductible for Tier 3

Through the designated mail service 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, reduced, or increased for certain covered drugs and supplies.

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

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

\$300 per calendar year per policy

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

\$300 per calendar year per policy

Mind and Body Wellness Program

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

\$300 per calendar year per policy

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

QUESTIONS?

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

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

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

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$2,000 individual contract / \$4,000 family contract.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive</u> care and prenatal care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	\$6,550 member / \$13,100 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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

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

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

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

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

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's [marketplace](#), if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Does this [plan](#) provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care [plan](#). It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

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

This EXAMPLE event includes services like:

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

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

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

What isn't covered

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

Managing Joe's Type 2 Diabetes

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

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

This EXAMPLE event includes services like:

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

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

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

What isn't covered

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

Mia's Simple Fracture

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

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

This EXAMPLE event includes services like:

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

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

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

What isn't covered

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

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

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MASSACHUSETTS

INFORMATION ABOUT THE PLAN

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

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NETWORK BLUE® SELECT \$300 DEDUCTIBLE

Plan-Year Deductible: \$300/\$900

MIIA Town of Boxborough

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



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

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



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Your Primary Care Provider (PCP)

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

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

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

Referrals

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

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

Your Deductible

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

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and copayments for covered services. Your out-of-pocket maximum for medical benefits is **\$2,000** per member (or **\$4,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$3,000** per member (or **\$6,000** per family).

Emergency Room Services

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

Telehealth Services

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

Your Virtual Care Team

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

Value Care Offering Coverage

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

Service Area

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

When Outside the Service Area

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

Dependent Benefits

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 12 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	\$20 per visit, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$45 per visit, no deductible
Mental health or substance use treatment	\$20 per visit, no deductible
Outpatient telehealth services	Same as in-person visit \$20 per visit, no deductible
• With a covered provider	
• With the designated telehealth vendor	
Chiropractors' office visits (up to 12 visits per calendar year)	\$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$45 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$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	\$20 per visit***, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$45 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$250 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission after deductible
Rehabilitation hospital care (up to 100 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

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

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

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

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

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

No deductible

\$10 for Tier 1
\$30 for Tier 2
\$65 for Tier 3

Through the designated mail service or designated retail pharmacy

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

No deductible

\$25 for Tier 1
\$75 for Tier 2
\$165 for Tier 3

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

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

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

Wellness Participation Program

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

\$300 per calendar year per policy

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

\$300 per calendar year per policy

Mind and Body Wellness Program

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

\$300 per calendar year per policy

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

QUESTIONS?

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

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

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$300 member / \$900 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , prenatal care, <u>prescription drugs</u> , most office visits, mental health visits, therapy visits; emergency transportation.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, \$2,000 member / \$4,000 family; and for <u>prescription drug</u> benefits, \$3,000 member / \$6,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$45 / visit; \$20 / chiropractor visit; \$45 / acupuncture visit	Not covered	Limited to 12 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$100	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication	Generic drugs	In-Network (You will pay the least) \$10 / retail supply or \$25 / designated retail or mail service supply	Out-of-Network (You will pay the most) Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$30 / retail supply or \$75 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$65 / retail supply or \$165 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$20 / visit	\$20 / visit	Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable

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

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

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care (12 visits per calendar year)
- Hearing aids (\$5,000 per ear every 36 months)
- Infertility treatment
- Routine eye care - adult (one exam every 12 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$300 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's [marketplace](#), if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Does this [plan](#) provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care [plan](#). It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$300
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$500
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

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

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

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

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$860

Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist visit copay</u>	\$45
■ <u>Primary care visit copay</u>	\$20
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

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

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

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist visit copay</u>	\$45
■ <u>Emergency room copay</u>	\$100
■ <u>Ambulance services copay</u>	\$0

This EXAMPLE event includes services like:

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

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

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

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$600

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

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MASSACHUSETTS

MCC COMPLIANCE



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



MASSACHUSETTS

INFORMATION ABOUT THE PLAN

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

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ACCESS BLUE NEW ENGLAND SAVER

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

MIIA Town of Boxborough

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



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



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

YOUR CARE

Access

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

Primary Care Provider (PCP)

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

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

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

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

Your Deductible

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

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical and prescription drug benefits is **\$6,550** per member (or **\$13,100** per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay nothing for emergency room services.

Telehealth Services

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

Your Virtual Care Team

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

Service Area

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

When Outside the Service Area

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

Dependent Benefits

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

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

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

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

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

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

\$10 after deductible for Tier 1

\$30 after deductible for Tier 2

\$65 after deductible for Tier 3

Through the designated mail service 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, reduced, or increased for certain covered drugs and supplies.

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

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

\$300 per calendar year per policy

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

\$300 per calendar year per policy

Mind and Body Wellness Program

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

\$300 per calendar year per policy

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

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

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

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$2,000 individual contract / \$4,000 family contract.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive</u> care and prenatal care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	\$6,550 member / \$13,100 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

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

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

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

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

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's [marketplace](#), if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Does this [plan](#) provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care [plan](#). It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

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

This EXAMPLE event includes services like:

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

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

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

What isn't covered

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

Managing Joe's Type 2 Diabetes

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

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

This EXAMPLE event includes services like:

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

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

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

What isn't covered

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

Mia's Simple Fracture

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

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

This EXAMPLE event includes services like:

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

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

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

What isn't covered

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

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

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MASSACHUSETTS

MCC COMPLIANCE



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

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BLUE CARE ELECT \$300 DEDUCTIBLE

Plan-Year Deductible: \$300/\$900

MIIA Town of Boxborough

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



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



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

YOUR CHOICE

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each 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 **\$300** per member (or **\$900** 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.

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 are still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider

To find a preferred provider:

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

When You Choose Non-Preferred Providers

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

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

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximums for medical benefits are **\$2,000** per member (or **\$4,000** per family) for in-network services and **\$3,000** per member (or **\$6,000** per family) for out-of-network services. Your out-of-pocket maximum for prescription drug benefits is **\$3,000** per member (or **\$6,000** per family).

Emergency Room Services

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

Telehealth Services

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

Your Virtual Care Team

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

Value Care Offering Coverage

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

Utilization Review Requirements

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

Dependent Benefits

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> Ten visits during the first year of life Three visits during the second year of life (age 1 to age 2) Two visits for age 2 One visit per calendar year for age 3 and older 	Nothing, 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
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 12 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 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: <ul style="list-style-type: none"> 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 \$45 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Mental health or substance use treatment	\$20 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services <ul style="list-style-type: none"> With a covered provider With the in-network designated telehealth vendor 	Same as in-person visit \$20 per visit, no deductible	Same as in-person visit Only applicable in-network
Chiropractors' office visits (up to 12 visits per calendar year)	\$20 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	\$45 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$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: <ul style="list-style-type: none"> 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 \$45 per visit***, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$250 per admission after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible

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

** 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.

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 \$30 for Tier 2 \$65 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 \$25 for Tier 1 \$75 for Tier 2 \$165 for Tier 3	Not covered

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

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

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

Wellness Participation Program

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

\$300 per calendar year per policy

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

\$300 per calendar year per policy

Mind and Body Wellness Program

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

\$300 per calendar year per policy

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

QUESTIONS?

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

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

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

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$300 member / \$900 family in-network; \$400 member / \$800 family out-of-network.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. In-network preventive and prenatal care, most office visits, therapy visits, mental health visits, <u>prescription drugs</u> ; emergency transportation.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	For medical benefits, \$2,000 member / \$4,000 family in-network and \$3,000 member / \$6,000 family out-of-network; and for <u>prescription drug</u> benefits, \$3,000 member / \$6,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric <u>specialist</u> , nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care; a telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$45 / visit; \$20 / chiropractor visit; \$45 / acupuncture visit	20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit	<u>Deductible</u> applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 12 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; <u>cost share</u> waived for at least one mental health wellness exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	\$100	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$25 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$30 / retail supply or \$75 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$65 / retail supply or \$165 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	In-network <u>deductible</u> applies first for in-network and out-of-network services; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>cost share</u> may be waived or reduced for certain services; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$500 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 / admission	20% <u>coinsurance</u>	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to one exam every 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% <u>coinsurance</u> for members with a cleft palate / cleft lip condition	<u>Deductible</u> applies first for out-of-network; limited to members under age 18

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's [marketplace](#), if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

Does this [plan](#) provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care [plan](#). It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$300
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$500
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

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

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

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

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$860

Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist visit copay</u>	\$45
■ <u>Primary care visit copay</u>	\$20
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

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

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

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist visit copay</u>	\$45
■ <u>Emergency room copay</u>	\$100
■ <u>Ambulance services copay</u>	\$0

This EXAMPLE event includes services like:

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

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

In this example, Mia would pay:

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

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$600

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

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MASSACHUSETTS

MCC COMPLIANCE



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

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MASSACHUSETTS

FIND A DOCTOR NEAR YOU

Looking for a doctor, hospital, or other health care professional? With our Find a Doctor & Estimate Costs tool, the care you need is just a few clicks away. Search for the type of provider or procedure you're looking for, then review a detailed list of options from your plan's network.

THE EASY WAY TO FIND CARE



Search by name, specialty, facility, and keyword, or browse by category. Plus, get cost estimates for more than 1,500 common procedures.



Compare up to five doctors at once, use filters to narrow your results, and review provider quality ratings.



View in-depth provider profiles, which include specialties, languages, contact information, and whether they're accepting new patients.

HERE'S HOW TO START SEARCHING:

For Current Members

1. Sign in to your MyBlue account at bluecrossma.org, or create a new one.
2. Select Find a Doctor & Estimate Costs.
3. Search for doctors, hospitals, and other providers.

Not a Member Yet?

You can still use the Find a Doctor tool before your coverage begins.

1. Visit bluecrossma.com/findadoctor.
2. Fill in all fields, including your plan's network and your preferred search area.
3. Select Search.

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

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

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

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

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MASSACHUSETTS

DOCTORS ON CALL, ON YOUR DEVICE.

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



REAL DOCTORS. REAL EXPERIENCE. REALLY FAST.



GET MEDICAL CARE 24/7

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



THERAPY THAT COMES TO YOU

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



HIGHLY EXPERIENCED, HIGHLY RATED

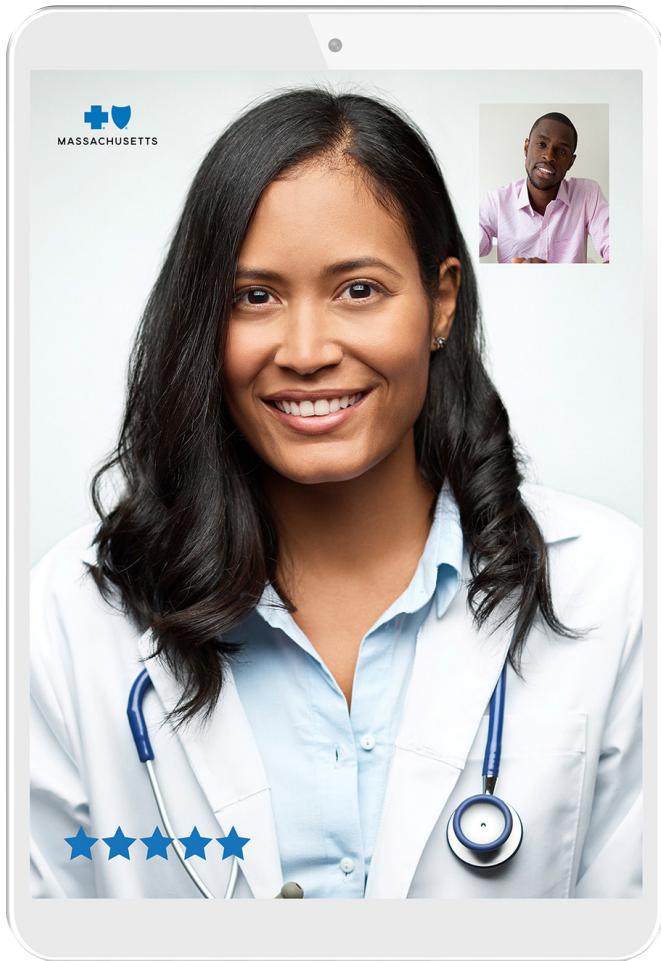
Qualified providers. Rated 4.8/5 stars and averaging 15 years of experience.²

Sign In

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

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

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



IS A VIDEO DOCTOR VISIT RIGHT FOR ME?

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

"I'm not feeling well."

Get care for:

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

"I need emotional support."

Talk to a therapist about:

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

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

"My loved one is under the weather."

If they're on your plan:

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



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

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

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

4. Prescription availability is defined by doctor judgment.

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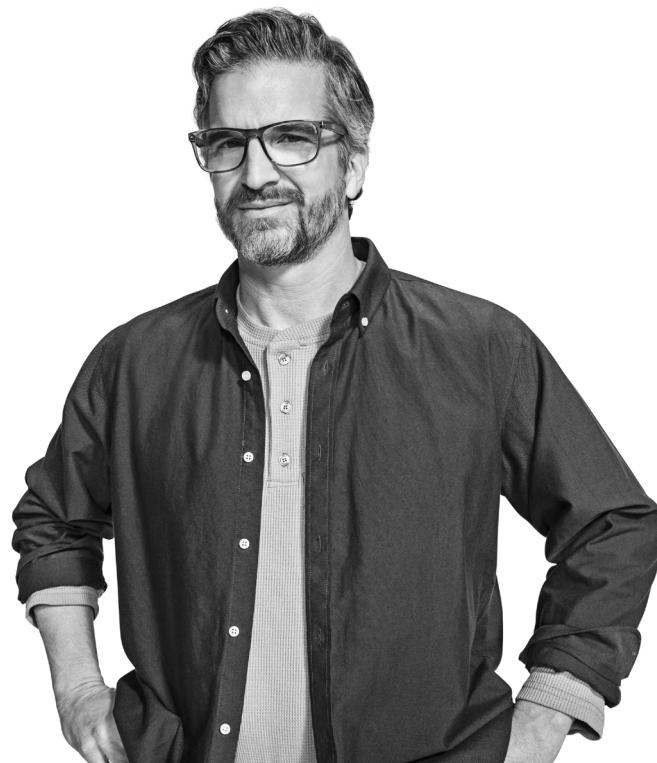
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MASSACHUSETTS

SAVE TIME AND MONEY WITH MAINTENANCE CHOICE VOLUNTARY

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



SWITCHING BRINGS BENEFITS



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



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



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



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

EXAMPLE OF HOW YOU CAN SAVE³

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

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

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

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

(Continued)

HOW TO SWITCH TO 90-DAY FILLS



Participating retail pharmacy

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

To find a participating pharmacy:

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



Mail service pharmacy

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



STAY CONNECTED

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

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

Questions?

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

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MASSACHUSETTS

SAVING SHOULD ALWAYS BE THIS EASY

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

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

There are two ways to be enrolled:

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

HOW THE PROGRAM WORKS



Fill your prescription

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



Enjoy instant savings

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



Get personalized, ongoing support

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

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

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

Questions?

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

(Continued)

What is a manufacturer's coupon?

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

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

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

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

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

Am I required to be enrolled in the program?

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

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

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

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

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

How does the program affect my deductible?

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

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

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

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

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

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

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

See if your medication is eligible

To see a list of eligible medications:

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

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

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

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START SAVING TODAY

with exclusive discounts just for
Blue Cross Blue Shield members.

What if there was a way for you to save money on what you and your family need most?

Say hello to Blue365! It's available to you as a Blue Cross Blue Shield member and free to register. Access year-round discounts on affordable solutions to support your health. And unlike some other discount programs, there's no need to earn rewards or points in order to take advantage of these exclusive deals—you *can start saving immediately!*

Enjoy one-of-a-kind discounts on:



Fitness Gear & Apparel



Gym Memberships



Hearing Aids



Nutrition



Vision Care

...And much more!



Sign up for free today by visiting Blue365deals.com or scan the code:



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Blue365[®]

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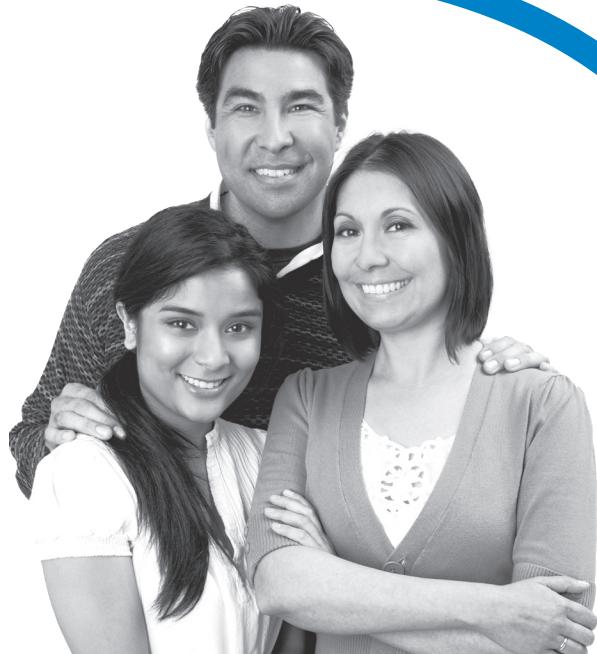
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MASSACHUSETTS

GET YOUR NO-COST FLU SHOT

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



WHERE TO GET YOUR SHOT

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



LEARN MORE

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



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

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

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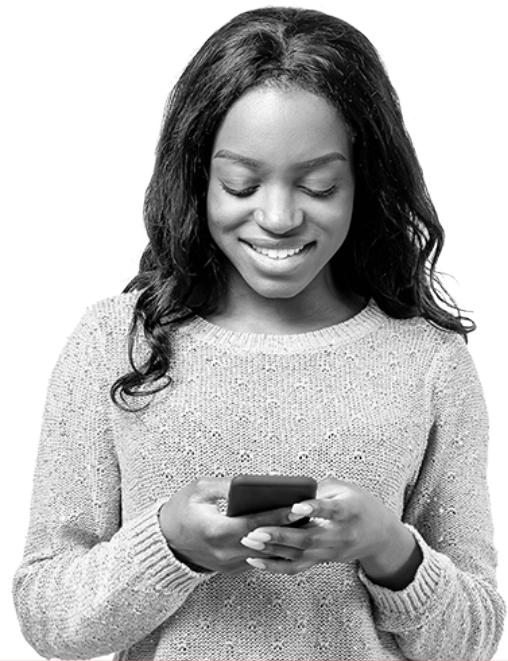


MASSACHUSETTS

QUESTIONS ABOUT YOUR PLAN?

Call Member Service:

1-800-262-BLUE (2583)



GET MORE FROM YOUR PLAN

Understanding your benefits is the best way to get the most from your plan.
Call Member Service when you have questions about:

- Coverage
- Claims
- Deductibles
- Copays
- Pharmacy benefits
- Medications
- Prior Authorization
- MyBlue
- ID card replacement
- Fitness and weight-loss reimbursements
- Billing
- Coverage when traveling
- Pre-existing conditions
- Care management

Questions?

Give Us a Call – Monday through Friday, 8:00 a.m. to 8:00 p.m. ET.



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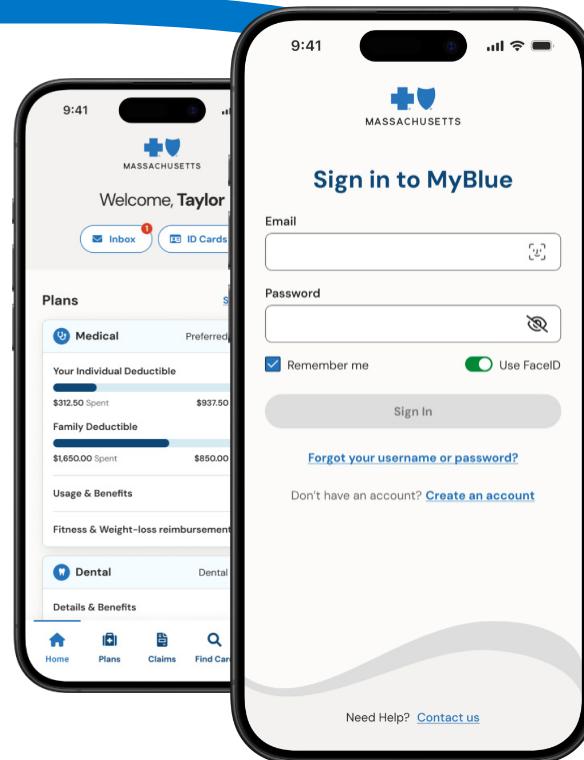
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EASILY ACCESS YOUR HEALTH PLAN WITH MYBLUE

MyBlue is your personalized online member account that makes understanding and using your health plan simple.



DISCOVER THE POWER OF MYBLUE

Stay on top of your health from anywhere, at any time with access to:



COVERAGE AND
BENEFITS INFORMATION



YOUR CLAIMS
AND BALANCES



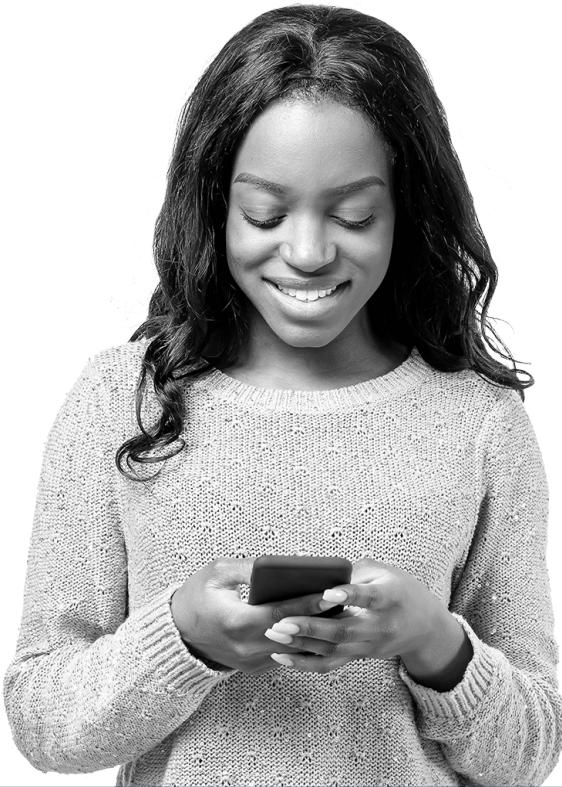
VIDEO DOCTOR VISITS
USING WELL CONNECTION

Get started

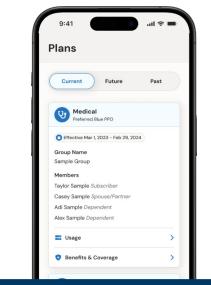
Create an account at bluecrossma.org or download the app from the App Store® or Google Play™. If you have questions, call Member Service at 1-800-832-3871.

YOUR HEALTH PLAN IN YOUR POCKET

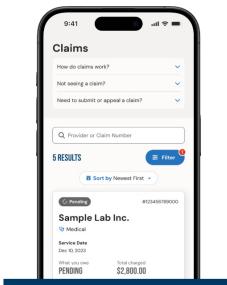
The MyBlue app makes it easy to:



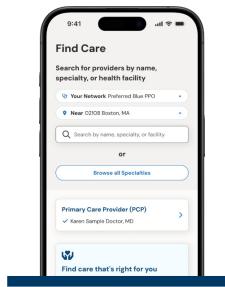
Download the MyBlue app and see your covered benefits and services by clicking on Benefits & Coverage under Plans.



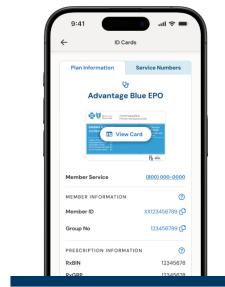
Find, understand, and use your benefits



Review your claim details with guidance on next steps



Get personalized care options that fit your unique needs



Instantly access your digital members ID cards, and add them to your wallet



GET THE MYBLUE APP

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



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GETTING MORE. NOW THERE'S A PLAN.

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

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



UNLOCK THE POWER OF YOUR PLAN

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



COVERAGE
AND BENEFITS



CLAIMS AND
BALANCES



FITNESS AND WEIGHT-
LOSS REIMBURSEMENT



MEDICATION
LOOKUP



VIDEO
DOCTOR VISITS USING
WELL CONNECTION

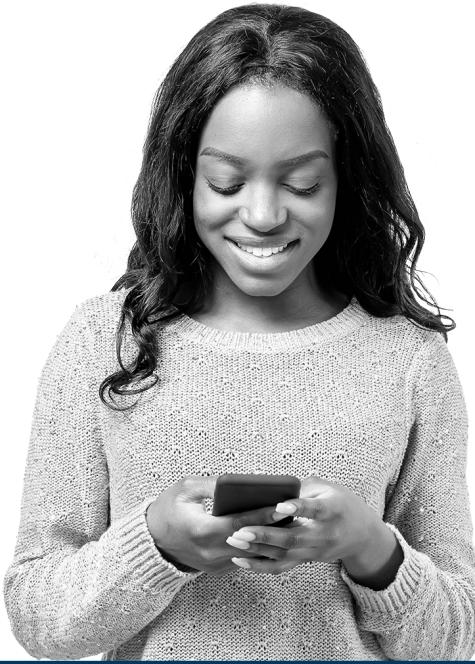
Get the App

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

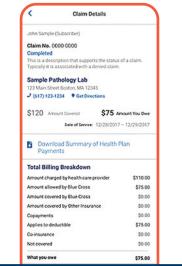
STAY ON TOP OF YOUR COVERAGE

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

YOUR PLAN IN YOUR HAND

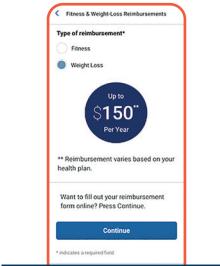


Once you sign in or create a MyBlue App account, you can see all of your benefits, all in one place. Track your claims, medications, account balances, and more from your device. And, you can easily keep track of reimbursements and savings.



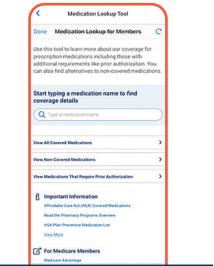
Track claims and benefits

Keep up to date on benefits and coverage.



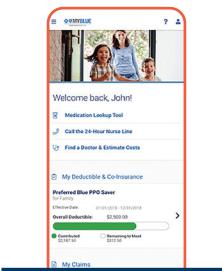
Fitness and weight-loss reimbursement

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



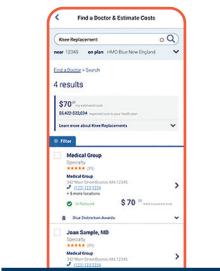
Your medications at a glance

Their names, costs, and prescriptions at your fingertips.



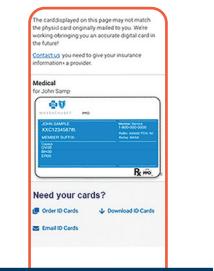
Check deductible balances

End the guesswork and know for sure every time.



Find a Doctor

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



Need your cards

Access your ID cards without opening your wallet.



GET THE MYBLUE APP

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WE SPECIALIZE IN MEDICAL CERTAINTY

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

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

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

WHO IS ELIGIBLE?

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

GET STARTED TODAY

Call at **1.866.841.2575**

Visit www.2nd.MD/miia

or download our **2nd.MD** app



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



HOW IT WORKS: 3 Simple Steps

1. ACTIVATE YOUR ACCOUNT AND REQUEST A CONSULT

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

2. SPEAK WITH A NURSE

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

3. CONSULT WITH A LEADING SPECIALIST

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

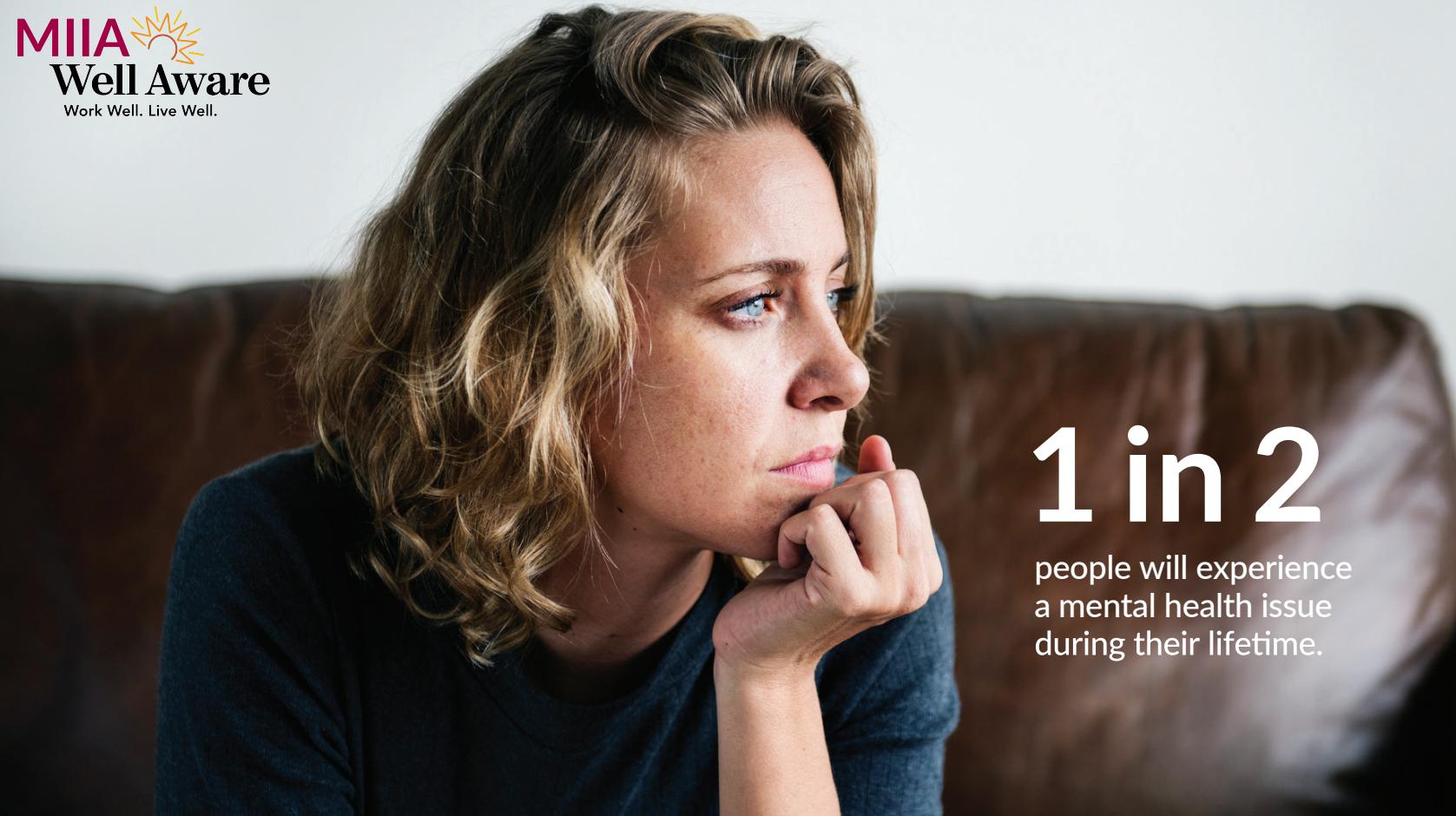
AFTER YOUR CONSULTATION

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

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



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1 in 2

people will experience
a mental health issue
during their lifetime.

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



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

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

Learn to Live benefits:

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

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

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

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

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A WHOLE NEW WAY TO DO PRIMARY CARE

Your Virtual Care Team is coming

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



PRIMARY CARE THAT'S A PRIME EXPERIENCE

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



CONVENIENT

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



COMPREHENSIVE

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



COORDINATED

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

SIGN UP TODAY!

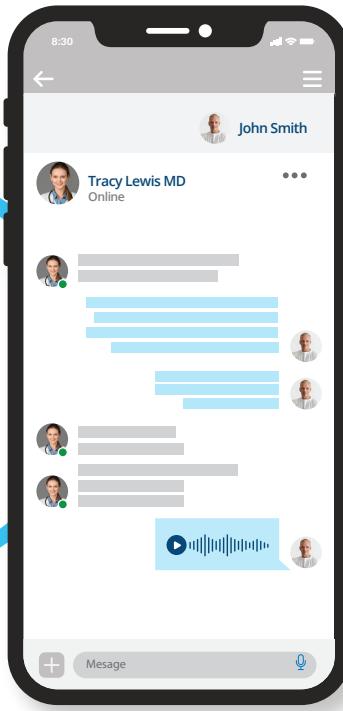
Log into your MyBlue account to get started.

HERE'S HOW IT WORKS

START BY PICKING
YOUR VIRTUAL PCP

ENJOY MORE
CONVENIENT CARE

GET THE BEST
OF BOTH WORLDS



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

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

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

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

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

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

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

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Earn cash rewards with SmartShopper!

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

Medical procedure costs vary by location.

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

Here's how it works



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



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



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



Visit bluecrossma.org or call the SmartShopper Personal Assistant Team at **1-877-281-3722**. The Personal Assistant Team is available to help you shop, find a location, compare costs, confirm rewards and even schedule your appointment. Call today! **Go Green by going paperless! Contact us or scan this code to register your email today.**



MASSACHUSETTS

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

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

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SmartShopper®

EARN MONEY WITH SMARTSHOPPER®

SmartShopper is an incentive and engagement program managed by Zelis®, an independent company. You can earn a reward check each time you or your covered family members choose an eligible lower-cost, quality doctor or facility for the health services below. Rewards range from \$15–\$400, depending on the procedure. To find a reward-eligible doctor or hospital for your recommended procedure, sign in to bluecrossma.com/myblue, or call Zelis' Care Concierge Team at 1-877-281-3722.

Keep this list for future reference.

Save on these health care services and procedure categories:

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

The dollar amount you receive may be considered taxable income. Consult your tax advisor.

SmartShopper is managed by Zelis®, an independent company. Members with coverage under Medicaid or Medicare (including as secondary payer) aren't eligible to receive incentive rewards under the SmartShopper program.

For HMO Blue plans, only network providers located in Massachusetts may qualify for rewards.



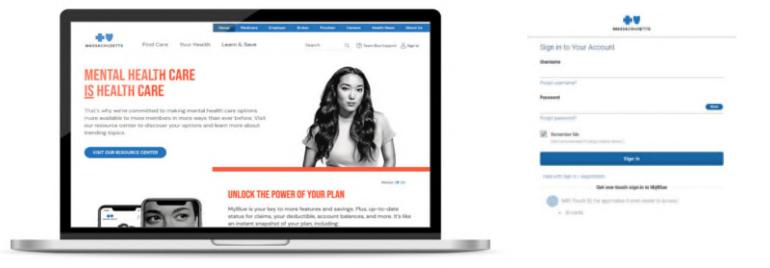
MASSACHUSETTS

GETTING STARTED WITH SMARTSHOPPER®

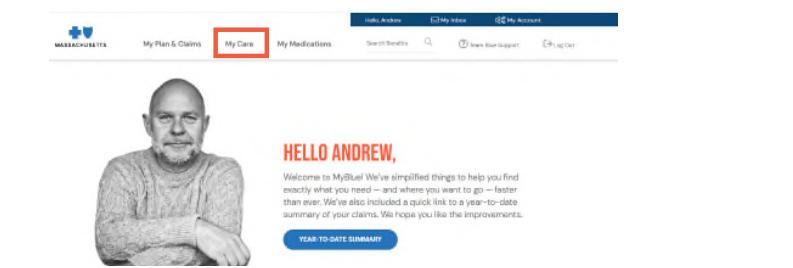
Earning up to \$400 is as easy as 1-2-3.

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

1 Sign in to MyBlue or create an account
Visit bluecrossma.org to sign in, or click **Create Account** to register for a new one.



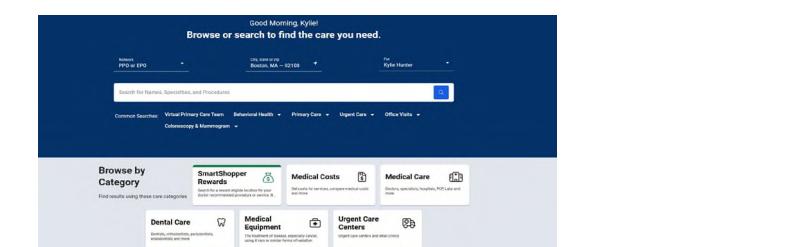
2 Go to My Care



3 Click Start Saving with SmartShopper



4 Search for provider Names, Specialties and Procedures



Questions?

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



MASSACHUSETTS

The dollar amount you receive may be considered taxable income. Consult your tax advisor. SmartShopper is managed by Zelis, an independent company. Members with coverage under Medicaid or Medicare (including as secondary payer) are not eligible to receive incentive rewards under the SmartShopper Program. For HMO Blue plans, only network providers located in Massachusetts may qualify for rewards. Some plans and services may require a referral from your doctor. Be sure to check your benefits or call Member Service at the number on the back of your ID card.

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SUPPORT FOR YOUR MATERNITY JOURNEY

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



Maternity Care Management

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



Lactation Consultations

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



24/7 Nurse Line

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



Breast Pump Savings

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



Childbirth Course Reimbursement

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



Maternal Mental Health Support

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

Learn More

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

MYBLUE IS HERE TO HELP

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



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



MASSACHUSETTS

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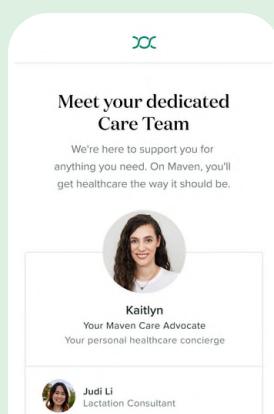
Meet Maven. Free virtual support for family building, pregnancy, parenting, and menopause.

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

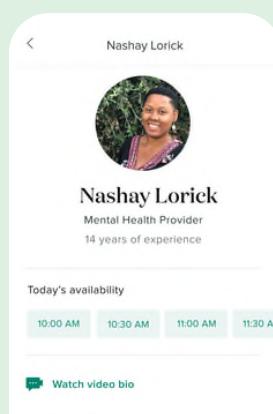


Here's what you and your partner get with Maven:

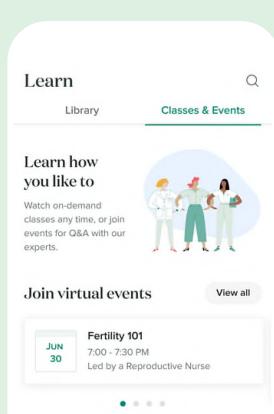
24/7 personalized support from a dedicated Care Advocate



Virtual appointments and messaging with specialists—anytime day or night



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



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



From starting a family

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



to having a child

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



to navigating parenthood

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



to managing all stages of menopause

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



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

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

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MASSACHUSETTS

YOUR URGENT CARE OPTIONS



24/7 NURSE LINE

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

Cost:

Time:

Severity:



WELL CONNECTION

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

Cost:

Time:

Severity:



DOCTOR'S OFFICE

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

Cost:

Time:

Severity:



LIMITED SERVICE CLINICS

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

Cost:

Time:

Severity:



URGENT CARE

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

Cost:

Time:

Severity:



EMERGENCY ROOM

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

Cost:

Time:

Severity:

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

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

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FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

\$300



Qualified for Reimbursement:

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



Not Qualified for Reimbursement:

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

GET STARTED!

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

Your reimbursement is waiting!

FITNESS REIMBURSEMENT REQUEST

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

Subscriber Information (Policyholder)			
Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial
Address – Number and Street	City	State	ZIP Code
Employer's Name			
Claim Information			
Member's Last Name	First Name	Middle Initial	Date of Birth ____/____/____
Claim is for (choose one and color in the entire box): <input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Spouse (of policyholder) <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Dependent (up to age 26) <input type="checkbox"/> Other (specify): _____	Name, Address, and Phone Number of Qualified Fitness Expense Total Dollars requested for Qualified Fitness Expense: \$ _____ Calendar year that fees were paid: _____		

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

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

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

Subscriber's or Member's Signature:

Date: ____/____/____

Complete this form and mail it to:

Blue Cross Blue Shield of Massachusetts,
Local Claims Department,
PO Box 986030, Boston, MA 02298

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

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

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WEIGHT-LOSS REIMBURSEMENT

Your reward for healthy behavior: Receive up to \$300 annually when you participate in a qualified weight-loss program.¹



Qualified for Weight-Loss Reimbursement

Participation fees for:

- Hospital-based programs and Weight Watchers® in-person
- Weight Watchers online and other non-hospital programs (in-person or online) that combine healthy eating, exercise, and coaching sessions with certified health professionals such as nutritionists, registered dietitians, or exercise physiologists.



Not Qualified for Weight-Loss Reimbursement

- One-time initiation or termination fees
- Food, supplements, books, scales, or exercise equipment
- Individual nutrition counseling sessions, doctor/nurse visits, lab tests, or other services that are covered benefits under your medical plan

1

Choose

Start by picking a qualified weight-loss program.

2

Complete

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

3

Mail

Send the completed form to the address listed.

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

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

Questions?

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

WEIGHT-LOSS REIMBURSEMENT REQUEST

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

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

Subscriber Information (Policyholder)			
Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial
Address - Number and Street	City	State	Zip Code
Employer's Name			
Claim Information			
Member Last Name	First Name	Middle Initial	Gender (color in the entire box) <input type="checkbox"/> Male <input type="checkbox"/> Female
Claim is for (choose one and color in the entire box):		Name, Address, and Phone Number of Qualified Weight-Loss Program	
<input type="checkbox"/> Subscriber (policyholder)	Total dollars requested: \$ _____		
<input type="checkbox"/> Spouse (of policyholder)	Monthly program participation fee: \$ _____		
<input type="checkbox"/> Ex-Spouse	Calendar Year: ____/____/____		
<input type="checkbox"/> Dependent (up to age 26)			
<input type="checkbox"/> Other (specify): _____			
Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so consult your tax advisor.			
Certification and Authorization (This form must be signed and dated below.) I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified weight-loss program to Blue Cross Blue Shield of Massachusetts.			Date: ____/____/____
Subscriber's or Member's Signature:			
Important Information: <ul style="list-style-type: none">Weight-loss reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a completed request.Reimbursement requests must be submitted by March 31 of the following year.Keep copies of proof of payment in case we request it from you. Proof of payment includes:<ul style="list-style-type: none">Receipts (cash/check/credit/electronic) for participation fees clearly documenting your name, the weight-loss program name, and individual amounts charged with date paid.Your weight-loss program membership or participation agreement clearly documenting your name and date of enrollment/participation.Your reimbursement may be considered taxable income, so consult a tax advisor.			
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MIND AND BODY REIMBURSEMENT

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

Save up to

\$300

per family per calendar year.



Qualified for Mind and Body Reimbursement:^{*}

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



Not Qualified for Mind and Body Reimbursement:

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

Find a Qualified Provider and Save

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

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

GET REIMBURSED IN THREE EASY STEPS

1

Choose

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

2

Complete

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

3

Mail

Send the completed form to the address listed.

Questions?

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

MIND AND BODY REIMBURSEMENT REQUEST

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

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

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

Important Information:

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

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HEALTH ENHANCEMENT PROGRAMS

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

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

HEALTH ENHANCEMENT PROGRAMS



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

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

HEALTH ENHANCEMENT PROGRAMS

For MIIA/Blue Cross Blue Shield Subscribers



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

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

HEALTH ENHANCEMENT PROGRAMS

For MIIA/Blue Cross Blue Shield Subscribers



PROGRAM	ELIGIBILITY	DESCRIPTION	GET STARTED
	Headspace	MIIA/Blue Cross Blue Shield Subscribers. Subscribers may enroll and invite 5 friends or family to join Headspace, free of charge (regardless of health plan status).	Learn more about Headspace Enroll in Headspace
	Hinge Health	MIIA/Blue Cross Blue Shield subscribers, spouses, and dependents (age 18+) on an active health plan.	Learn more about Hinge Health Enroll in Hinge Health
	Maven	24/7 Virtual support for Family Building, Pregnancy, Parenting, and Menopause.	Learn more about Maven Enroll in Maven

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

HEALTH ENHANCEMENT PROGRAMS

For MIIA/Blue Cross Blue Shield Subscribers



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

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

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

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

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

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

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

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

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

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

Complaint forms are available at hhs.gov.

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PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

Arabic/عَرَبِيَّة:

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

Mon-Khmer, Cambodian/ខ្មែរ: ការដែនដំណឹង៖ ប្រសិនបើអ្នកនឹងយាយភាសា ខ្មែរ សេវាដំនឹងយាយភាសាតំនើត តើអាជរការណ៍សម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្ទៀកសេវាសមាជិកតាមលេខទ័រលេខបណ្តុះសម្រាប់ខ្លួនរបស់អ្នក (TTY: **711**)។

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

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

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

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

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

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

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

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

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

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

Persian/پارسیان:

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

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

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