



Effective: 7/1/2023

WELCOME GATEWAY HEALTH GROUP-LAKEVILLE

GET THE MOST OUT OF YOUR PLAN



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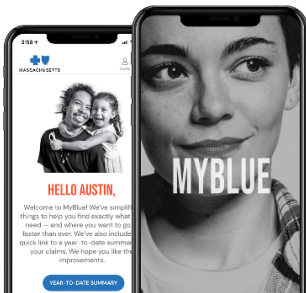
FIND A DOCTOR



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Medicare



YOUR PLAN IN YOUR HAND

Get an instant snapshot of your health care.

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BLUE CARE ELECT PREFERRED

Gateway Health Group

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



This health plan 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

When You Choose Preferred Providers

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

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

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.

You must pay a calendar-year deductible before you can receive coverage for certain out-of-network benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible is **\$250** per member (or **\$500** per family).

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

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximums are **\$2,000** per member (or **\$4,000** per family) for in-network services and **\$1,000** per member (or **\$2,000** per family) for out-of-network services. Your out-of-pocket maximum for prescription drug benefits is **\$2,000** per member (or **\$4,000** 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). You pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

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

Your Virtual Care Team

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

Utilization Review Requirements

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

Dependent Benefits

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older 	Nothing	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing	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	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one per calendar year)	Nothing	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	\$100 per visit (waived if admitted or for observation stay)	\$100 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits	\$25 per visit	20% coinsurance after deductible
Mental health or substance use treatment	\$25 per visit	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 \$25 per visit	Same as in-person visit Only applicable in-network
Chiropractors' office visits	\$25 per visit	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	\$25 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$25 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$25 per visit	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$50 per category per service date	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance after deductible**
Prosthetic devices	Nothing	20% coinsurance after deductible
Surgery and related anesthesia <ul style="list-style-type: none"> • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit 	\$25 per visit*** \$50 per admission	20% coinsurance after deductible 20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% coinsurance after deductible

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

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

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	\$10 for Tier 1 \$25 for Tier 2 \$45 for Tier 3	Not covered
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	\$20 for Tier 1 \$50 for Tier 2 \$90 for Tier 3	Not covered

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

\$150 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.)

\$150 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.gatewayhealthgroup.com. 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 <u>deductible</u>?	\$0 in-network; \$250 member / \$500 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Emergency room and 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For medical benefits, \$2,000 member / \$4,000 family in-network; \$1,000 member / \$2,000 family out-of-network; and for <u>prescription drug</u> benefits, \$2,000 member / \$4,000 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 <u>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> .
Will you pay less if you use a <u>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.
Do you need a <u>referral</u> to see a <u>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	\$25 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$25 / visit; \$25 / chiropractor visit; \$25 / 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; 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; 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	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	\$50	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$45 / retail supply or \$90 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <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> does not apply	<u>Copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$25 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; 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	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <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 for out-of-network; 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	No charge	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 for out-of-network; <u>pre-authorization</u> required
	<u>Rehabilitation services</u>	\$25 / 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 for out-of-network; limited to 100 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$25 / 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 for out-of-network; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; in-network <u>cost share</u> waived for one breast pump per birth, including supplies (20% <u>coinsurance</u> for out-of-network)
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; <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 per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% <u>coinsurance</u> for members with a cleft palate / cleft lip condition	<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 | • Dental care (Adult) | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | |

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

- | | | |
|--|---|---|
| • Acupuncture (12 visits per calendar year) | • Infertility treatment | • Routine foot care (only for patients with systemic circulatory disease) |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (\$150 per calendar year per policy) |
| • Chiropractic care | • Routine eye care - adult (one exam per calendar year) | |
| • Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger) | | |

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

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

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <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:

Cost sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$70

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> visit <u>copay</u>	\$25
■ <u>Primary care</u> visit <u>copay</u>	\$25
■ <u>Diagnostic tests</u> <u>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:

Cost sharing

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

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture (in-network emergency room visit and follow-up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> visit <u>copay</u>	\$25
■ <u>Emergency room</u> <u>copay</u>	\$100
■ <u>Ambulance services</u> <u>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:

Cost sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$200

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

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

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



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 Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a calendar year for copayments and coinsurance for covered services. The calendar year begins on January 1 and ends on December 31 of each year. 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 **\$2,000** per member (or **\$4,000** 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). You pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

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

Your Virtual Care Team

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

Service Area

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

When Outside the Service Area

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

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
Preventive dental care for children under age 12 (one visit each six months)	Nothing
Routine adult physical exams, including related tests	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing
Routine hearing exams, including routine tests	Nothing
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum
Routine vision exams (one every 12 months)	Nothing
Family planning services—office visits	Nothing
Outpatient Care	
Emergency room visits	\$100 per visit (waived if admitted or for observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care Other covered providers, including a physician assistant or nurse practitioner designated as specialty care 	\$15 per visit \$25 per visit
Mental health or substance use treatment	\$15 per visit
Outpatient telehealth services <ul style="list-style-type: none"> With a covered provider With the designated telehealth vendor 	Same as in-person visit \$15 per visit
Chiropractors' office visits	\$25 per visit
Acupuncture visits (up to 12 visits per calendar year)	\$25 per visit
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$25 per visit
Speech, hearing, and language disorder treatment—speech therapy	\$15 per visit
Diagnostic X-rays and lab tests	Nothing
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$50 per category per service date
Home health care and hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**
Prosthetic devices	Nothing
Surgery and related anesthesia in an office or health center, when performed by: <ul style="list-style-type: none"> Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care Other covered providers, including a physician assistant or nurse practitioner designated as specialty care 	\$15 per visit*** \$25 per visit***
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$50 per admission
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	Nothing
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing

* 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)**	\$10 for Tier 1 \$25 for Tier 2 \$45 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	\$20 for Tier 1 \$50 for Tier 2 \$90 for Tier 3
<small>* 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 or reduced for certain covered drugs and supplies.</small>	
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.)	\$150 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.)	\$150 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.gatewayhealthgroup.com. 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?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For medical benefits, \$2,000 member / \$4,000 family; and for <u>prescription drug</u> benefits, \$2,000 member / \$4,000 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 <u>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> .
Will you pay less if you use a <u>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.
Do you need a <u>referral</u> to see a <u>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> .

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$25 / visit; \$25 / chiropractor visit; \$25 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$50	Not covered	<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 prescription drug coverage is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$45 / retail supply or \$90 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; <u>cost share</u> may be waived or reduced 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)	\$50 / admission	Not covered	<u>Pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	<u>Copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$25 / visit	\$25 / 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)	No charge	Not covered	<u>Pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	No charge	Not covered	<u>Pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	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>Pre-authorization</u> required
	<u>Rehabilitation services</u>	\$25 / visit for physical or occupational therapy (\$15 / visit for speech therapy) for outpatient services; No charge for inpatient services	Not covered	Limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$25 / visit for physical or occupational therapy (\$15 / visit for speech therapy)	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	Limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam 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
- 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 (\$150 per calendar year per policy)

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

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

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <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>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> visit <u>copay</u>	\$25
■ <u>Primary care</u> visit <u>copay</u>	\$15
■ <u>Diagnostic tests</u> <u>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>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture (in-network emergency room visit and follow-up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> visit <u>copay</u>	\$25
■ <u>Emergency room</u> <u>copay</u>	\$100
■ <u>Ambulance services</u> <u>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>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$200

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

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NETWORK BLUE[®] SELECT \$1,000 DEDUCTIBLE

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Plan-Year Deductible: \$1,000/\$2,000

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



CLAIMS AND
BALANCES



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



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 **\$1,000** per member (or **\$2,000** per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$5,450** per member (or **\$10,900** per family). Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** per family).

Emergency Room Services

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

Telehealth Services

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

Service Area

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

When Outside the Service Area

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

Dependent Benefits

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

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$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 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$150 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care Other covered providers, including a physician assistant or nurse practitioner designated as specialty care 	\$20 per visit, no deductible \$35 per visit, no deductible
Mental health or substance use treatment	\$20 per visit, no deductible
Outpatient telehealth services <ul style="list-style-type: none"> With a covered provider With the designated telehealth vendor 	Same as in-person visit \$20 per visit, no deductible
Chiropractors' office visits	\$35 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$35 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$35 per visit after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$35 per visit 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, no deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: <ul style="list-style-type: none"> Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care Other covered providers, including a physician assistant or nurse practitioner designated as specialty care 	\$20 per visit***, no deductible \$35 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	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, no deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

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

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

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

† Deductible waived for mental health admissions.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible \$15 for Tier 1 \$30 for Tier 2 \$50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$30 for Tier 1 \$60 for Tier 2 \$150 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 or reduced 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.)

\$150 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.)

\$150 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.gatewayhealthgroup.com. 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 <u>deductible</u>?	\$1,000 member / \$2,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> , prenatal care, emergency room, <u>prescription drugs</u> , most office visits, mental health services, emergency transportation, <u>home health care</u> , and <u>hospice services</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For medical benefits, \$5,450 member / \$10,900 family; and for <u>prescription drug</u> benefits, \$1,000 member / \$2,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>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> .
Will you pay less if you use a <u>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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$35 / visit; \$35 / chiropractor visit; \$35 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	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 prescription drug coverage is available at bluecrossma.org/medication	Generic drugs	\$15 / retail supply or \$30 / 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 for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$30 / retail supply or \$60 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$50 / retail supply or \$150 / 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 or reduced 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>	\$150 / visit; <u>deductible</u> does not apply	\$150 / visit; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$35 / visit	\$35 / 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)	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	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	No charge	Not covered	<u>Pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	<u>Deductible</u> applies first for childbirth/delivery facility services; <u>cost sharing</u> does not apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	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>Pre-authorization</u> required
	<u>Rehabilitation services</u>	\$35 / visit for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first; limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$35 / visit	Not covered	<u>Deductible</u> applies first; 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>	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	Not covered	Limited to members under age 18

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$150 per calendar year per policy)

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

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

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	\$1,000
■ Delivery fee copay	\$0
■ Facility fee copay	\$0
■ Diagnostic tests copay	\$0

This EXAMPLE event includes services like:

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

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

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,070

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

■ The plan's overall deductible	\$1,000
■ Specialist visit copay	\$35
■ Primary care visit copay	\$20
■ Diagnostic tests copay	\$0

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
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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
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture (in-network emergency room visit and follow-up care)

■ The plan's overall deductible	\$1,000
■ Specialist visit copay	\$35
■ Emergency room copay	\$150
■ Ambulance services copay	\$0

This EXAMPLE event includes services like:

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

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

<u>Cost sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
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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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

Gateway Health Group

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

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



This health plan 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 (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is **\$5,000** per member (or **\$10,000** 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 the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **After meeting your deductible, for outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your benefit description, or call the Member Service number on your ID card.

Service Area

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

When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. 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
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$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 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits	Nothing after deductible
Mental health or substance use treatment	Nothing after deductible
Outpatient telehealth services <ul style="list-style-type: none"> • With a covered provider • With the designated telehealth vendor 	Same as in-person visit Nothing after deductible
Chiropractors' office visits	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	20% coinsurance after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia	Nothing after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

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

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

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	\$10 after deductible for Tier 1 \$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 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.)	\$150 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.)	\$150 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.gatewayhealthgroup.com. 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 <u>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.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> 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/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$5,000 member / \$10,000 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 <u>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> .
Will you pay less if you use a <u>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.
Do you need a <u>referral</u> to see a <u>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 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 prescription drug coverage 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 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>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>	\$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	<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
	<u>Rehabilitation services</u>	No charge for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first; limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>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 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>	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>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 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	Not covered	Limited to members under age 18

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$150 per calendar year per policy)

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

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

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)

■ The <u>plan's</u> overall <u>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
<i>What isn't covered</i>	
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)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> visit <u>copay</u>	\$0
■ <u>Primary care</u> visit <u>copay</u>	\$0
■ <u>Diagnostic tests</u> <u>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
<i>What isn't covered</i>	
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)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> visit <u>copay</u>	\$0
■ <u>Emergency room</u> <u>copay</u>	\$100
■ <u>Ambulance services</u> <u>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
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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

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

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DENTAL BLUE[®] PPO PROGRAM 1

Gateway Health Group

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



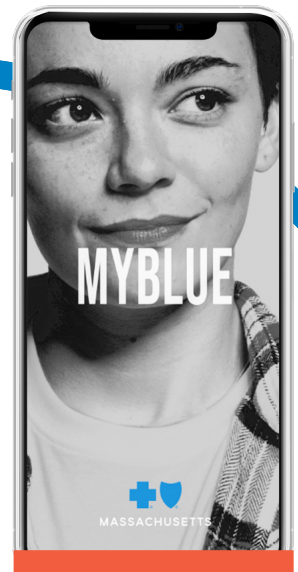
CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

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



DENTAL BLUE PPO PROGRAM 1

Preventive Benefit Group	Basic Benefit Group
No Deductible	
Full Coverage*	80% Coverage*
\$500 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)	
<p>Diagnostic</p> <ul style="list-style-type: none"> • One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures • Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months • Bitewing X-rays twice per calendar year • Single tooth X-rays as needed • Study models and casts used in planning treatment once each 60 months • Periodic or routine oral exams twice per calendar year • Emergency exams <p>Preventive</p> <ul style="list-style-type: none"> • Routine cleaning, scaling, and polishing of the teeth twice per calendar year • Fluoride treatment twice per calendar year (members under age 19) • Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per bicuspid or molar surface each 48 months. • Space maintainers needed due to premature tooth loss (members under age 19) 	<p>Restorative</p> <ul style="list-style-type: none"> • Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period) • Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period) • Pin retention for fillings • Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16) <p>Oral Surgery</p> <ul style="list-style-type: none"> • Tooth extraction • Root removal • Biopsies <p>Periodontics (gum and bone)</p> <ul style="list-style-type: none"> • Periodontal scaling and root planing once per quadrant each 24 months • Periodontal surgery once per quadrant each 36 months • Periodontal maintenance following active periodontal therapy once each three months <p>Endodontics (roots and pulp)</p> <ul style="list-style-type: none"> • Root canal therapy (permanent teeth, once in a lifetime per tooth) • Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth • Therapeutic pulpotomy on primary or permanent teeth (members under age 16) • Other endodontic surgery to treat or remove the dental root <p>Prosthetic Maintenance</p> <ul style="list-style-type: none"> • Repair of partial or complete dentures, crowns, and bridges once each 12 months • Adding teeth to an existing complete or partial denture • Rebase or reline of dentures once each 36 months • Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months <p>Other Services</p> <ul style="list-style-type: none"> • Occlusal adjustments once each 24 months • Services to treat root sensitivity • General anesthesia when administered in conjunction with covered surgical services • Emergency dental care to treat acute pain or to prevent permanent harm to a member**

* Benefits are reduced by 20 percent when services are received from an out-of-network dentist.

** When you require emergency care by an out-of-network dentist, benefits are provided at the same level as an in-network dentist.

WELCOME TO DENTAL BLUE PPO,

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

Your Dentist

Dental Blue PPO offers a large network of dentists, including dentists in Massachusetts and Rhode Island who participate with Blue Cross Blue Shield of Massachusetts. Dental Blue PPO members also have access to participating dentists nationwide. Using Dental Blue PPO network dentists will minimize your out-of-pocket expenses.

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

Your Benefits

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

Pre-Treatment Estimates

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

Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

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

Multi-Stage Procedures

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

You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Network Dentists Are Paid

Payments are based on the allowed charge for covered services. Network dentists agree to accept the allowed charge as payment in full. You pay only your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year benefit maximum. In certain situations, you will have to pay the difference between the claim payment and the provider's actual billed charge. Refer to your plan description for information about these situations.

How Out-of-Network Dentists Are Paid

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

Payments are based on 80 percent of the network coverage levels for covered services. For example, if 80 percent of your dental expenses would have been covered had you used a network provider, only 64 percent of such expenses will be covered if you use an out-of-network provider. This provision does not apply to emergency care services. Benefits for emergency care are paid based on the network level of benefits.

When Coverage Begins

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

Dependent Benefits

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

Enhanced Dental Benefits

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

If You Have to File a Claim

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

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

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

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

Other Information

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

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

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 800-932-8323, or visit us online at bluecrossma.org.

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

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MASSACHUSETTS

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

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

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

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

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

BENEFITS YOU CAN SEE — FROM A COMPANY YOU TRUST



ACCESS TO ONE OF
THE NATION'S LARGEST
VISION NETWORKS



THOUSANDS OF
INDEPENDENT PROVIDERS



AWARD-WINNING
CUSTOMER SERVICE

FAVORITE NATIONAL RETAILERS

LENSCRAFTERS®

PEARLE VISION

OPTICAL

and many regional retailers.

ONLINE SHOPPING OPTIONS

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

ADDITIONAL IN-NETWORK SAVINGS AND DISCOUNTS

40%

off a complete
second pair of glasses

20%

off non-prescription
sunglasses

15%

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

SAVE ON HEARING EXAMS AND HEARING AIDS

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

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

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

Questions?

Call Blue 20/20 Customer Service at 1-855-875-6948.
To locate an in-network provider, create an account at blue2020ma.com.



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

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

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

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MASSACHUSETTS

OUR NEW PHARMACY BENEFIT MANAGER: FREQUENTLY ASKED QUESTIONS

How the Change Will—and Won't—Affect You

On January 1, 2023, a new pharmacy benefit manager will begin administering pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts. Most members will experience few or no changes as a result of this transition. Learn why we're making this change and how we'll support you through it.

Why is Blue Cross changing its pharmacy benefit manager?

Now more than ever, controlling the rising cost of health care is critical. The cost of prescription medications is growing the fastest, and that cost accounts for almost 20% of your premium. Working with our new pharmacy benefit manager, we believe we can better manage the effect of medication prices on your health care premiums.

What will this change mean for me?

The change to a new pharmacy benefit manager will mean few or no changes for most members, as the prescription medications we cover and the terms of coverage will remain the same for some medications. Also, most of our current network pharmacies will remain in-network.

If you're going to be affected by the change to a new pharmacy benefit manager, we'll let you know by mail and we'll guide you through any action you need to take.

Will I get a new ID card?

Yes. A new Blue Cross ID card with updated pharmacy information will be mailed to Medicare members in October. All other members will receive their new Blue Cross ID cards in December.

Starting January 1, 2023, you'll need to present the new ID card for any pharmacy products or services. You can also access your digital ID card on MyBlue after January 1. Destroy your old card before disposing of it.

What types of changes should I anticipate?

Mail Service Pharmacy

There will be a new mail service pharmacy. If you use the mail order pharmacy, your prescription(s) will transfer automatically, except for controlled-substance prescriptions, and prescriptions with no refills remaining. In those cases, you'll need to ask your doctor for new prescriptions.

Formulary (the medications we cover)

We review and make changes to our formularies each year. Depending on the formulary, changes can be made up to four times per year. This frequency will continue under the new pharmacy benefit manager.

Formulary changes can include changes to prescription medications, tiers, dosing requirements, and step therapy. As always, we'll notify you and your health care provider in advance about any such changes.

How can I access the new mail service pharmacy?

On or after January 1, 2023, sign in to MyBlue to access the mail service pharmacy website. When refilling your prescriptions, you'll be prompted to add your billing information. Don't forget to enroll in auto-refill and to select your communication preferences.

You can also enroll in the mail service pharmacy by calling CVS Customer Care at **1-877-817-0477** TTY: **711** (for commercial members) or **1-877-817-0493** TTY: **711** (for Medicare members).

(continued)

Will the cost of my medication(s) change?

Some medications will be categorized into a different tier, which would affect their costs. If that's the case for any medications you're taking, you'll be notified by letter.

Can I look up my medications to check coverage terms and tier information before January 1, 2023?

Yes. Starting in October 2022, you can use the Medication Lookup Tool or the Medicare Medication Lookup Tool to learn about your 2023 prescription drug coverage information. Find both tools on MyBlue (bluecrossma.org).

Will my current pharmacy be part of the new pharmacy benefit manager network?

Almost certainly. You'll have access to an extensive pharmacy network, which includes CVS Pharmacy™, Rite Aid™, and Walgreens pharmacies, as well as thousands of independent pharmacies. If the pharmacy you use now isn't in the new pharmacy benefit manager's network, we'll let you know by mail. In October 2022, you can use our Find a Pharmacy locator tool to find in-network pharmacy options near you.

I use specialty medication(s). Will the network of specialty pharmacies be changing?

No. Our network of retail specialty pharmacies will remain the same as of January 1, 2023.

Will the member site (MyBlue) be updated, in light of this change?

Yes. There will be enhancements to MyBlue, including the 2023 Medication Lookup Tool (available in October 2022), access to digital ID cards, and more.

How can I use MyBlue to help me prepare for the upcoming pharmacy benefit manager change?

Create a MyBlue account at bluecrossma.org, if you haven't already done so, or sign in to your existing MyBlue account. You can use MyBlue to instantly manage your medications, review your pharmacy claims, and learn about your pharmacy benefits and all your other benefits—all in one place.

How will I know if I'm affected by the pharmacy benefit manager transition?

Medicare members will be notified of any changes to their prescription drug benefit through the standard "Annual Notice of Change" (issued in late September 2022), as well as through individual communications (issued in November 2022).

All other members will be notified in November about any related pharmacy changes that affect them.

Mail order prescriptions filled before January 1, 2023, will be processed by your current mail order pharmacy, Express Scripts Pharmacy.

Plan ahead if you'll need to refill a prescription before year's end, to ensure that you have an adequate supply.

Questions?

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



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

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MASSACHUSETTS

SAVE TIME AND MONEY WITH THE MAIL ORDER WITH RETAIL CHOICE PROGRAM



The Mail Order with Retail Choice Program 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 prescription through the mail service pharmacy.

BENEFITS OF THE PROGRAM



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



No additional cost for standard shipping.



No more rushing to the pharmacy.

WHAT HAPPENS IF I DON'T SWITCH?

Switching to the mail service pharmacy isn't a requirement of the program. You can opt out annually from using the mail service pharmacy by calling CVS Customer Care at 1-877-817-0477 (TTY: 711), and continue to fill your prescriptions at a retail pharmacy. **If you don't opt out, you'll be responsible for paying the full retail cost of your medications.** To give you time to switch or opt out, we'll provide coverage for your first two 30-day fills at a retail pharmacy. Just pay your regular copay. On your third fill, if you don't opt out, you'll be responsible for the full retail amount.

Questions?

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

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

EXAMPLE OF HOW YOU CAN SAVE²

TYPE OF PRESCRIPTION	MEDICATION COPAY		
	Tier 1	Tier 2	Tier 3
30-day supply, retail pharmacy	\$15	\$30	\$50
90-day supply, mail service pharmacy	\$30	\$60	\$150

HOW TO SWITCH TO THE MAIL SERVICE PHARMACY

- 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 **Start Rx Delivery by Mail** under **Prescriptions**.



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

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MASSACHUSETTS

SAVE MONEY WITH THE MANDATORY MAIL PROGRAM

Save 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 through the mail service pharmacy.



SWITCHING BRINGS BENEFITS



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



No additional cost for standard delivery.



Signing up for automatic refills makes it less likely to miss a dose.

WHAT HAPPENS IF YOU DON'T SWITCH

Switching is required if you want to be covered by your plan. **If you don't switch your maintenance medications to 90-day supplies through the mail service pharmacy by your third fill, you'll be responsible for paying the full retail cost of eligible medications.** While you make the transition, we'll provide coverage for two 30-day fills at a retail pharmacy. Just pay your regular copay.

Questions?

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

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

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EXAMPLE OF HOW YOU CAN SAVE²

TYPE OF PRESCRIPTION	MEDICATION COPAY		
	Tier 1	Tier 2	Tier 3
30-day supply, retail pharmacy	\$15	\$30	\$50
90-day supply, mail service pharmacy	\$30	\$60	\$150

HOW TO SWITCH TO THE 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**.



MASSACHUSETTS

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

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SAVE MONEY ON YOUR MEDICATIONS WITH THE MAIL SERVICE PHARMACY

Maintenance medications, also known as long-term medications, are used to treat chronic or ongoing conditions. Save 33% when you order them in 90-day supplies through the mail service pharmacy.¹



BENEFITS OF USING THE MAIL SERVICE PHARMACY



You'll pay 33% less for 90-day supplies of most maintenance medications (that's one less copay).



There's no additional cost for standard delivery.



Signing up for automatic refills makes it less likely to miss a dose.

EXAMPLE OF HOW YOU'LL SAVE²

TYPE OF PRESCRIPTION	MEDICATION COPAY		
	Tier 1	Tier 2	Tier 3
30-day supply, retail pharmacy	\$15	\$30	\$50
90-day supply, mail service pharmacy	\$30	\$60	\$150

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

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

HOW TO USE THE MAIL SERVICE PHARMACY

Download the MyBlue app or create an account at bluecrossma.org. Once signed in, click **Pharmacy Benefit Manager** under **My Medications**, then go to the **Prescriptions** tab. To:

TRANSFER PRESCRIPTIONS

Click
Start Rx Delivery by Mail

ORDER REFILLS

Click
View/Refill All Prescriptions

SET UP AUTOMATIC REFILLS

Click
Manage Automatic Refills

You can also fill prescriptions by calling CVS Customer Care at **1-877-817-0477** (TTY: **711**), or by using the included order form.

WHY ISN'T MY MEDICATION AVAILABLE THROUGH THE MAIL SERVICE PHARMACY?

Certain medications that require immediate administration or are used for short periods of time aren't available through the mail service pharmacy. In addition, some specialty medications are only available through specialty pharmacies.

Please Note:

Certain prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions about your medication, call CVS Customer Care at **1-877-817-0477** (TTY: **711**).

It's the patient's responsibility to report any changes in drug allergies, health conditions, chronic diseases, and drug sensitivities.

Prescription information about members and dependents is used to administer your prescription program. That information is reported to Blue Cross Blue Shield of Massachusetts, and is used for reporting and analysis, without identifying individual patients in accordance with applicable laws.

Questions?

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



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Mail Service Order Form

Mail this form to:



CVS Caremark
PO BOX 659541
SAN ANTONIO, TX 78265-9541

Member ID # (if not shown or if different from above)

Prescription Plan Sponsor or Company Name

Instructions:

Please use **blue or black ink** and **print in capital letters**. Fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form.

Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below.

Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at bluecrossma.org.
Go to **90-Day Mail Service** under **My Medications**.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name First Name MI Suffix (JR, SR)

Street Address Apt./Suite # Use shipping address for this order only.

City State ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1) _____ 2) _____ 3) _____ 4) _____
5) _____ 6) _____ 7) _____ 8) _____

CVS Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

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We may package all of these prescriptions together unless you tell us not to.
All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.



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* WEB *

* WEB *

C Tell us about the people ordering prescriptions. If there are more than two people, please complete another form.

First person with a refill or new prescription.

Spanish forms and labels

Last Name

Nickname

First Name MI Suffix (JR,SR)

Date of birth: MM-DD-YYYY --

E-mail address: _____ Date new prescription written: _____

Doctor's last name _____ Doctor's first name _____ Doctor's phone # _____

Tell us about new health information for 1st person if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin
 Sulfa Other: _____

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem
 High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid
 Other: _____

Second person with a refill or new prescription.

Spanish forms and labels

Last Name

Nickname

First Name MI Suffix (JR,SR)

Date of birth: MM-DD-YYYY --

E-mail address: _____ Date new prescription written: _____

Doctor's last name _____ Doctor's first name _____ Doctor's phone # _____

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin
 Sulfa Other: _____

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem
 High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid
 Other: _____

D Special instructions: _____

E How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

Electronic check. Pay from your bank account. (You must first register online or call Customer Care.)

Credit or debit card. (VISA®, MasterCard®, Discover®, or American Express®)

- Use your card on file.
- Use a new card or update your card's expiration date.

Exp. Date MMY Y

Check or money order. Amount: \$.

- Make check or money order payable to CVS Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to \$40.

Payment for Balance Due and Future Orders: If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Credit card holder signature/Date

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

- 2nd business day (\$17)** Faster delivery can only be sent to a street address, not a PO Box
- Next business day (\$23)**

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



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MASSACHUSETTS

DENTAL BLUE[®] ENHANCED DENTAL BENEFITS

Additional Support for Members with Qualifying Conditions

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

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

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

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

NO ADDITIONAL COST TO RECEIVE THESE EXTRA SERVICES*

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

*Qualifying members only.

Questions?

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

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ENHANCED DENTAL BENEFITS ENROLLMENT FORM

Dear Physician:

This is an application for your patient to receive Enhanced Dental Benefits from Blue Cross Blue Shield of Massachusetts. These Enhanced Dental Benefits will provide coverage for additional preventive services to this Dental Blue® member if diagnosed with one or more of the qualifying medical conditions listed below. Please complete this form so that your patient may receive Enhanced Dental Benefits. Thank you.

(Note: Your patient's dental coverage policy must include Enhanced Dental Benefits in order to be eligible for coverage.)

Please check qualifying medical conditions:

- Diabetes
- Coronary Artery Disease
- Stroke
- Oral Cancer
- Sjögren's Syndrome
- Pregnancy (Expected date of birth ___/___/___)

Subscriber/Member Information

Subscriber Name		Member Name		Date of Birth ___/___/___
Member Address		City	State	ZIP Code
Member Telephone # (Home)		Member Telephone # (Other)		
Blue Cross Blue Shield of Massachusetts Dental ID #				

Physician Information

I hereby confirm that my patient has been diagnosed with the conditions listed above.			Date ___/___/___
Physician Signature			
Physician Name (please print, circle MD or DO) MD/DO		License #	State
Physician Address		Physician Telephone #	

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

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



MASSACHUSETTS

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

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

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

NURSES RIGHT NOW

When you call our 24/7 Nurse Line, you can speak to a registered nurse, when you need to, day or night. Because guidance and advice should be available around the clock.



YES, YOUR PLAN COVERS IT!



GET CONNECTED
DIRECTLY TO A NURSE



365 DAYS A YEAR,
INCLUDING HOLIDAYS



THERE'S NO
ADDITIONAL COST

KNOW WHEN TO CALL

Nurses can give you advice on:

- Treating a fever, cut, headache, or diarrhea
- Managing a new diagnosis
- Recognizing signs of a concussion after a head injury
- Taking over-the-counter medications or prescriptions
- Upcoming medical tests or appointments
- Deciding if you need immediate care
- Caring for a sick child or family member

In the case of a life-threatening emergency, call 911 or go to the nearest emergency room.

Call Our 24/7 Nurse Line

Nurses are ready around the clock to answer your questions. Call **1-888-247-BLUE (2583)**.

*We partner with Carenet Health®, an independent health care engagement company, to administer this service. Before you can email a nurse, you'll need to create a Carenet Health account using your nine-digit Blue Cross member ID number (without the letter prefix).

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.



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MASSACHUSETTS

WEIGHT-LOSS REIMBURSEMENT

Your reward for healthy behavior:
Receive up to \$150 annually when you participate in a qualified weight-loss program.¹



Qualified for Weight-Loss Reimbursement

Participation fees for:

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



Not Qualified for Weight-Loss Reimbursement

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

GET REIMBURSED IN THREE EASY STEPS

1

Choose

Start by picking a qualified weight-loss program.

2

Complete

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

3

Mail

Send the completed form to the address listed.

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

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

Questions?

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

WEIGHT-LOSS REIMBURSEMENT REQUEST

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

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

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial
Address - Number and Street	City	State	Zip Code
Employer's Name			

Claim Information

Member Last Name	First Name	Middle Initial	Gender (color in the entire box) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth __/__/__
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Claim is for (choose one and color in the entire box):

- Subscriber (policyholder)
- Spouse (of policyholder)
- Ex-Spouse
- Dependent (up to age 26)
- Other (specify):

Name, Address, and Phone Number of Qualified Weight-Loss Program

Total dollars requested: \$ _____

Monthly program participation fee: \$ _____

Calendar Year: __/__/__

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

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

I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified weight-loss program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: _____

Date: __/__/__

Important Information:

- Weight-loss reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a completed request.
- Reimbursement requests must be submitted by March 31 of the following year.
- Keep copies of proof of payment in case we request it from you. Proof of payment includes:
 - Receipts (cash/check/credit/electronic) for participation fees clearly documenting your name, the weight-loss program name, and individual amounts charged with date paid.
 - Your weight-loss program membership or participation agreement clearly documenting your name and date of enrollment/participation.
- Your reimbursement may be considered taxable income, so consult a tax advisor.

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

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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

FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

\$150



Qualified for Reimbursement:

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



Not Qualified for Reimbursement:

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

Get Started

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

Your reimbursement is waiting!



MASSACHUSETTS

FITNESS REIMBURSEMENT REQUEST

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

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial
Address – Number and Street	City	State	ZIP Code
Employer's Name			

Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth __/__/__
Claim is for (choose one and color in the entire box): <input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Spouse (of policyholder) <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Dependent (up to age 26) <input type="checkbox"/> Other (specify): _____	Name, Address, and Phone Number of Qualified Fitness Expense		
	Total Dollars requested for Qualified Fitness Expense: \$ _____ Calendar year that fees were paid: _____		

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

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

Subscriber's or Member's Signature: _____ **Date:** __/__/__

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

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.
ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

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Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. 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 **civilrightscordinator@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 Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).

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

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

Arabic/العربية:

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

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

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

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

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

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

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

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निःशुल्क 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 شماره تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

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

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