



Effective: 7/1/2026



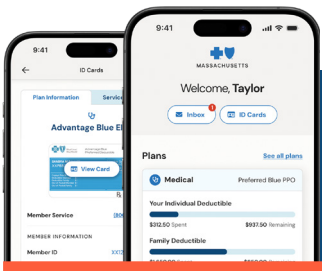
SMHG

[http://planinfo.bluecrossma.com/ekit/2026-smhg-en\\_US.pdf](http://planinfo.bluecrossma.com/ekit/2026-smhg-en_US.pdf)

View your complete plans details (over) >

### PLAN OPTIONS

<p> MEDICAL</p> <p><b>Network Blue NE Ded 250 with HCCS</b></p> <p>↓ SBC ↓ SUMMARY</p>	<p> MEDICAL</p> <p><b>Network Blue NE Enhanced Value</b></p> <p>↓ SBC ↓ SUMMARY</p>	<p> MEDICAL</p> <p><b>Access Blue NE Saver 2000</b></p> <p>↓ SBC ↓ SUMMARY</p>	<p> MEDICAL</p> <p><b>Access Blue NE Saver II 5000</b></p> <p>↓ SBC ↓ SUMMARY</p>
<p> MEDICAL</p> <p><b>Blue Care Elect Ded 250 with HCCS</b></p> <p>↓ SBC ↓ SUMMARY</p>	<p> MEDICAL</p> <p><b>Blue Care Elect Enhanced Value</b></p> <p>↓ SBC ↓ SUMMARY</p>	<p> MEDICAL</p> <p><b>Blue Care Elect Saver 2000</b></p> <p>↓ SBC ↓ SUMMARY</p>	



Get a personalized view of your plan  
MyBlue is your online member account that gives you instant access to your plan benefits from any device.

Get Started  
Register for MyBlue at [bluecrossma.org](http://bluecrossma.org) or download the app.

# PLAN DETAILS

## PLAN INFORMATION

- [Hospital Choice Cost Sharing \(HCCS\)](#) ↓
- [Find a Doctor & Estimate Costs](#) ↓
- [Telehealth](#) ↓
- [Out- of- Country Care](#) ↓
- [Virtual Primary Care](#) ↓
- [Health Savings Account](#) ↓

## WELLNESS

- [Blue 365](#) ↓
- [Pregnancy and Baby](#) ↓
- [Stopping the Flu Starts with You](#) ↓
- [Behavioral Health](#) ↓
- [Fitness Reimbursement](#) ↓
- [Weight- Loss Reimbursement](#) ↓
- [Mind and Body Reimbursement](#) ↓

## RESOURCES

- [Blue Card Program Brochure](#) ↓
- [Commitment To Confidentiality](#) ↓
- [SBC Glossary Medical Terms](#) ↓
- [Summary of Health Plan Payments Guide](#) ↓
- [MyBlue Fact Sheet](#) ↓
- [Flu Facts](#) ↓
- [24/ 7 Nurse Line](#) ↓
- [Learn About Tiers](#) ↓
- [Maintenance Choice Voluntary Member Fact Sheet](#) ↓
- [Mail Service Pharmacy Member Fact Sheet and Order Form](#) ↓
- [Well Connection](#) ↓
- [Hinge Health](#) ↓
- [SmartShopper®](#) ↓
- [Dependent Out of Area Coverage](#) ↓
- [MyBlue](#) ↓
- [Coordination of Benefits](#) ↓

Left Blank Intentionally

# NETWORK BLUE<sup>®</sup> NEW ENGLAND \$250 DEDUCTIBLE WITH HOSPITAL CHOICE COST SHARING

SMHG

Plan-Year Deductible: \$250/\$750

## TAP INTO YOUR HEALTH PLAN

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



Track claims  
and benefits



Find personalized  
care options



View your  
member ID card

### Get started

Sign in or create an account today. Download the app or visit [bluecrossma.org](http://bluecrossma.org).



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

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.

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



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

# YOUR CARE

## Your Primary Care Provider (PCP)

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

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

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

## Referrals

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

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

## Your Cost Share

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

## Higher Cost Share Hospitals

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

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

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

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

## Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$250** per member (or **\$750** per family).

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical and prescription drug benefits 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](http://bluecrossma.org), consult Find a Doctor, or call the Member Service number on your ID card.

## Your Virtual Care Team

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

## Service Area

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

## When Outside the Service Area

If you are traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. 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
<b>Preventive Care</b>	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
<b>Outpatient Care</b>	
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for an observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> <li>Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care</li> <li>Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</li> </ul>	\$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"> <li>With a covered provider</li> <li>With the designated telehealth vendor</li> </ul>	Same as in-person visit \$20 per visit, no deductible
Chiropractors' office visits	\$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$35 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible
Diagnostic x-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests <ul style="list-style-type: none"> <li>Hospitals</li> <li>Other covered providers</li> </ul>	\$100 per category per service date after deductible 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 in an office or health center, when performed by: <ul style="list-style-type: none"> <li>Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care</li> <li>Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</li> </ul>	\$20 per visit***, no deductible \$35 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission after deductible
<b>Inpatient Care (including maternity care) in:</b>	
<ul style="list-style-type: none"> <li>Other general hospitals (as many days as medically necessary)</li> <li>Higher cost share hospitals (as many days as medically necessary)</li> </ul>	\$300 per admission after deductible† \$700 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	\$300 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$200 per admission 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 or Down syndrome.

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

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

† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
<b>Prescription Drug Benefits*</b>	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$20 for Tier 1 \$50 for Tier 2 \$110 for Tier 3
<p>* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.</p> <p>** Cost share may be waived, reduced, or increased for certain covered drugs and supplies.</p>	
<p><b>Get the Most from Your Plan: Visit us at <a href="http://bluecrossma.org">bluecrossma.org</a> or call 1-800-932-8323 to learn about discounts, savings, resources, and special programs available to you, like those listed below.</b></p>	
<b>Wellness Participation Program</b>	
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
<b>Mind and Body Wellness Program</b>	
Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	\$300 per calendar year per policy
<p> <b>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.</b></p>	

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-932-8323, or visit us online at [bluecrossma.org](http://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.

Left Blank Intentionally



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 <https://semhg.org/>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$250 member / \$750 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> , prenatal care, <u>prescription drugs</u> , most office visits, mental health visits, and therapy visits.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	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; \$20 / 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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$100 for hospitals; No charge for other <u>providers</u>	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a>	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	This <u>plan</u> uses the Blue Cross Blue Shield of Massachusetts Formulary — Focused; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$50 / retail supply or \$110 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<b>If you need immediate medical attention</b>	<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>	\$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)	\$300 / admission; \$700 / admission for certain hospitals	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	\$200 / admission for mental hospitals or substance abuse facilities; \$300 / admission for general hospitals; \$700 / admission for certain hospitals	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	\$300 / admission; \$700 / admission for certain hospitals	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	\$20 / visit for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first except for outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, Down syndrome, <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>	\$20 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	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

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	Not covered	Limited to one exam every 24 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Children's glasses</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (12 visits per calendar year)</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> <li>• Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Routine eye care - adult (one exam every 24 months)</li> <li>• Routine foot care (only for patients with systemic circulatory disease)</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs (\$150 per calendar year per policy)</li> </ul>

**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](http://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](http://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](http://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](http://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](http://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 1-800-932-8323 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** **\$250**
- **Delivery fee copay** **\$0**
- **Facility fee copay** **\$300**
- **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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$610</b>

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

- **The plan's overall deductible** **\$250**
- **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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

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

- **The plan's overall deductible** **\$250**
- **Specialist visit copay** **\$35**
- **Emergency room copay** **\$100**
- **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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$450</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.  
\* Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



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 option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of cost share (such as copayments and coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from some network general hospitals, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at [bluecrossma.org/hospitalchoice](https://bluecrossma.org/hospitalchoice).

Left Blank Intentionally

# NETWORK BLUE<sup>®</sup> NEW ENGLAND VALUE

SMHG

## TAP INTO YOUR HEALTH PLAN

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



Track claims  
and benefits



Find personalized  
care options



View your  
member ID card

### Get started

Sign in or create an account today. Download the app or visit [bluecrossma.org](http://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](http://bluecrossma.org); consult Find a Doctor at [bluecrossma.com/findadoctor](http://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 deductible begins on January 1 and ends on December 31 of each year. Your out-of-pocket maximum for medical and prescription drug benefits 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). 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](http://bluecrossma.org), consult Find a Doctor, or call the Member Service number on your ID card.

## Your Virtual Care Team

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

## Service Area

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

## When Outside the Service Area

If you are traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. 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
<b>Preventive Care</b>	
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
Mental health wellness exams (at least 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 24 months)	Nothing
Family planning services—office visits	Nothing
<b>Outpatient Care</b>	
Emergency room visits	\$100 per visit (waived if admitted or for an observation stay)
Office or health center visits	\$25 per visit
Mental health or substance use treatment	\$25 per visit
Outpatient telehealth services <ul style="list-style-type: none"> <li>• With a covered provider</li> <li>• With the designated telehealth vendor</li> </ul>	Same as in-person visit \$25 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	\$25 per visit
Diagnostic x-rays and lab tests	Nothing
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Other covered providers</li> </ul>	\$75 per category per service date Nothing
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 <ul style="list-style-type: none"> <li>• Office or health center services</li> <li>• Ambulatory surgical facility, hospital outpatient department, or surgical day care unit</li> </ul>	Nothing \$250 per admission***
<b>Inpatient Care (including maternity care)</b>	
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission***
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission***
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 or Down syndrome.

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

\*\*\* Copayments for consecutive inpatient admissions (or day surgery followed by inpatient care) within 30 days for the same or related illness will not exceed \$500.

Covered Services	Your Cost
<b>Prescription Drug Benefits*</b>	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	\$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)**	\$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, reduced, or increased for certain covered drugs and supplies.

**Get the Most from Your Plan: Visit us at [bluecrossma.org](http://bluecrossma.org) or call 1-800-932-8323 to learn about discounts, savings, resources, and special programs available to you, like those listed below.**

<b>Wellness Participation Program</b> 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
<b>Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program</b> (See your benefit description for details.)	\$150 per calendar year per policy
<b>Mind and Body Wellness Program</b> Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	\$300 per calendar year per policy

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

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-932-8323, or visit us online at [bluecrossma.org](http://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.

Left Blank Intentionally



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 <https://semhg.org/>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 / 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.
<b>If you have a test</b>	<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)	\$75 for hospitals; No charge for other <u>providers</u>	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a>	Generic drugs	\$15 / retail supply or \$30 / designated retail or mail service supply	Not covered	This plan uses the Blue Cross Blue Shield of Massachusetts Formulary — Focused; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$30 / retail supply or \$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	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	Not covered	<u>Copayment</u> limited to \$500 for services within 30 days for the same or related illness; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Pre-authorization</u> required for certain services
<b>If you need immediate medical attention</b>	<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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500 / admission	Not covered	<u>Copayment</u> limited to \$500 for services within 30 days for the same or related illness; <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
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$500 / admission	Not covered	<u>Copayment</u> limited to \$500 for services within 30 days for the same or related illness; <u>pre-authorization</u> / authorization required for certain services
<b>If you are pregnant</b>	Office visits	No charge	Not covered	<u>Copayment</u> limited to \$500 for services within 30 days for the same or related illness; <u>cost sharing</u> does not apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$500 / admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	\$25 / visit for outpatient services; No charge for inpatient services	Not covered	Limited to 60 outpatient visits per calendar year (other than for autism, Down syndrome, <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	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
<b>If your child needs dental or eye care</b>	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	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 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](http://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](http://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](http://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](http://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](http://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 1-800-932-8323 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 \$0
- Delivery fee copay \$0
- Facility fee copay \$500
- 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)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$560</b>

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

- The plan's overall deductible \$0
- Specialist visit copay \$25
- Primary care visit copay \$25
- 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)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

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

- The plan's overall deductible \$0
- Specialist visit copay \$25
- Emergency room copay \$100
- 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)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**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
<b>The total Mia would pay is</b>	<b>\$200</b>

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

\* Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



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.

Left Blank Intentionally

# ACCESS BLUE NEW ENGLAND SAVER

SMHG

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

## TAP INTO YOUR HEALTH PLAN

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



Track claims  
and benefits



Find personalized  
care options



View your  
member ID card

### Get started

Sign in or create an account today. Download the app or visit [bluecrossma.org](http://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](http://bluecrossma.org); consult Find a Doctor at [bluecrossma.com/findadoctor](http://bluecrossma.com/findadoctor); or call the Member Service number on your ID card.

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

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

## Your Deductible

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

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and copayments for covered services. Your out-of-pocket maximum for medical and prescription drug benefits 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](http://bluecrossma.org), consult Find a Doctor, or call the Member Service number on your ID card.

## Your Virtual Care Team

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

## Service Area

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

## When Outside the Service Area

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

## Dependent Benefits

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

Covered Services	Your Cost
<b>Preventive Care</b>	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
<b>Outpatient Care</b>	
Emergency room visits	\$50 per visit after deductible (copayment waived if admitted or for an 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"> <li>• With a covered provider</li> <li>• With the designated telehealth vendor</li> </ul>	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	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia	Nothing after deductible
<b>Inpatient Care (including maternity care)</b>	
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 or Down syndrome.

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

Covered Services	Your Cost
<b>Prescription Drug Benefits*</b>	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	After deductible \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	After deductible \$20 for Tier 1 \$50 for Tier 2 \$110 for Tier 3

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

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

**Get the Most from Your Plan: Visit us at [bluecrossma.org](http://bluecrossma.org) or call 1-800-932-8323 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

#### Mind and Body Wellness Program

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

\$300 per calendar year per policy

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

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-932-8323, or visit us online at [bluecrossma.org](http://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.

Left Blank Intentionally



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 <https://semhg.org/>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$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.
<b>Are there services covered before you meet your deductible?</b>	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 cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$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.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> 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.
<b>Do you need a referral to see a specialist?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	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.
<b>If you have a test</b>	<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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a>	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	This plan uses the Blue Cross Blue Shield of Massachusetts Formulary — Focused; <u>deductible</u> applies first; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$50 / retail supply or \$110 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
<b>If you have outpatient surgery</b>	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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 / visit	\$50 / 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
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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	No charge for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first; limited to 60 outpatient visits per calendar year (other than for autism, Down syndrome, <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>	No charge	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<b>If your child needs dental or eye care</b>	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	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 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](http://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](http://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](http://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](http://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](http://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 1-800-932-8323 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Does this plan provide Minimum Essential Coverage? Yes.**

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

**Does this plan meet the Minimum Value Standards? Yes.**

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

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

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

## About these Coverage Examples:



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

### Peg is Having a Baby

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

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

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

#### Cost sharing

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

#### What isn't covered

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,070</b>

### Managing Joe's Type 2 Diabetes

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

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

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

#### Cost sharing

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

#### What isn't covered

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,720</b>

### Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$2,000
■ <u>Specialist visit copay</u>	\$0
■ <u>Emergency room copay</u>	\$50
■ <u>Ambulance services copay</u>	\$0

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

#### Cost sharing

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

#### What isn't covered

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,000</b>

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

\* Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

004692320 (4/26) LK



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.

Left Blank Intentionally

# ACCESS BLUE NEW ENGLAND SAVER II

SMHG

Plan-Year Deductible: \$5,000/\$10,000

## TAP INTO YOUR HEALTH PLAN

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



Track claims  
and benefits



Find personalized  
care options



View your  
member ID card

### Get started

Sign in or create an account today. Download the app or visit [bluecrossma.org](http://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](http://bluecrossma.org); consult Find a Doctor at [bluecrossma.com/findadoctor](http://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 **\$5,000** per member (or **\$10,000** per family). **No one member will have to pay more than the per member deductible.**

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and copayments for covered services. Your out-of-pocket maximum for medical and prescription drug benefits is **\$6,850** per member (or **\$13,700** 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](http://bluecrossma.org), consult Find a Doctor, or call the Member Service number on your ID card.

## Your Virtual Care Team

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

## Service Area

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

## When Outside the Service Area

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

## Dependent Benefits

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

Covered Services	Your Cost
<b>Preventive Care</b>	
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
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
<b>Outpatient Care</b>	
Emergency room visits	\$50 per visit after deductible (copayment waived if admitted or for an 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"> <li>• With a covered provider</li> <li>• With the designated telehealth vendor</li> </ul>	Same as in-person visit Nothing, no 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	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia	Nothing after deductible
<b>Inpatient Care (including maternity care)</b>	
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 or Down syndrome.

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

Covered Services	Your Cost
<b>Prescription Drug Benefits*</b>	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	After deductible \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	After deductible \$20 for Tier 1 \$50 for Tier 2 \$110 for Tier 3

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

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

**Get the Most from Your Plan: Visit us at [bluecrossma.org](http://bluecrossma.org) or call 1-800-932-8323 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

#### Mind and Body Wellness Program

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

\$300 per calendar year per policy

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

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-932-8323, or visit us online at [bluecrossma.org](http://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.

Left Blank Intentionally



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 <https://semhg.org/>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$5,000 member / \$10,000 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$6,850 member / \$13,700 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	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.
<b>If you have a test</b>	<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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a>	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	This plan uses the Blue Cross Blue Shield of Massachusetts Formulary — Focused; <u>deductible</u> applies first; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$50 / retail supply or \$110 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
<b>If you have outpatient surgery</b>	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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 / visit	\$50 / 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
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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	No charge for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first; limited to 60 outpatient visits per calendar year (other than for autism, Down syndrome, <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>	No charge	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<b>If your child needs dental or eye care</b>	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](http://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](http://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](http://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](http://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](http://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 1-800-932-8323 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>	\$5,000
■ <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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

#### In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,070</b>

### 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>	\$5,000
■ <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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

#### In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,120</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist</u> visit <u>copay</u>	\$0
■ <u>Emergency room</u> <u>copay</u>	\$50
■ <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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

#### In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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

\* Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



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.

Left Blank Intentionally

# BLUE CARE ELECT

# \$250 DEDUCTIBLE

## WITH HOSPITAL CHOICE COST SHARING

SMHG

Plan-Year Deductible: \$250/\$750

### TAP INTO YOUR HEALTH PLAN

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



Track claims  
and benefits



Find personalized  
care options



View your  
member ID card

#### Get started

Sign in or create an account today. Download the app or visit [bluecrossma.org](http://bluecrossma.org).



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

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.

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



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

# YOUR CHOICE

## Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductibles are **\$250** per member (or **\$750** per family) for in-network services and **\$400** per member (or **\$800** per family) for out-of-network services.

## When You Choose Preferred Providers

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

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

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

## Higher Cost Share Hospitals

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

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

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

## How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider on Find a Doctor at [bluecrossma.com/findadoctor](http://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](http://bluecrossma.org)

## When You Choose Non-Preferred Providers

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

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

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximums for medical and prescription drug benefits are **\$5,000** per member (or **\$10,000** per family) for in-network services and **\$3,000** per member for out-of-network services.

## Emergency Room Services

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

## Telehealth Services

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

## Your Virtual Care Team

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

## Utilization Review Requirements

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

## Dependent Benefits

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
<b>Preventive Care</b>		
Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> <li>Ten visits during the first year of life</li> <li>Three visits during the second year of life (age 1 to age 2)</li> <li>Two visits for age 2</li> <li>One visit per calendar year for age 3 and older</li> </ul>	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
<b>Outpatient Care</b>		
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for an observation stay)	\$100 per visit after in-network deductible (copayment waived if admitted or for an observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> <li>A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care</li> <li>Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</li> </ul>	\$20 per visit, no deductible	20% coinsurance after deductible
	\$35 per visit, no deductible	20% coinsurance after deductible
Mental health or substance use treatment	\$20 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services <ul style="list-style-type: none"> <li>With a covered provider</li> <li>With the in-network designated telehealth vendor</li> </ul>	Same as in-person visit \$20 per visit, no deductible	Same as in-person visit Only applicable in-network
Chiropractors' office visits	\$20 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	\$35 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic x-rays and lab tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests <ul style="list-style-type: none"> <li>Hospitals</li> <li>Other covered providers</li> </ul>	\$100 per category per service date after deductible Nothing after deductible	20% coinsurance after deductible 20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**	40% coinsurance after deductible**
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: <ul style="list-style-type: none"> <li>A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care</li> <li>Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</li> </ul>	\$20 per visit***, no deductible	20% coinsurance after deductible
	\$35 per visit***, no deductible	20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission after deductible	20% coinsurance after deductible
<b>Inpatient Care (including maternity care) in:</b>		
<ul style="list-style-type: none"> <li>Other general hospitals (as many days as medically necessary)</li> <li>In-network higher cost share hospitals (as many days as medically necessary)</li> </ul>	\$300 per admission after deductible† \$700 per admission after deductible†	20% coinsurance after deductible Only applicable in-network
Chronic disease hospital care (as many days as medically necessary)	\$300 per admission after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$200 per admission after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible

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

\*\* 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.

† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
<b>Prescription Drug Benefits*</b>		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3	Not covered
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$20 for Tier 1 \$50 for Tier 2 \$110 for Tier 3	Not covered

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

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

**Get the Most from Your Plan: Visit us at [bluecrossma.org](https://bluecrossma.org) or call 1-800-932-8323 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

#### Mind and Body Wellness Program

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

\$300 per calendar year per policy



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

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-932-8323, or visit us online at [bluecrossma.org](https://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.

Left Blank Intentionally



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 <https://semhg.org/>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$250 member / \$750 family in-network; \$400 member / \$800 family out-of-network.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, prescription drugs.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$5,000 member / \$10,000 family in-network; \$3,000 member out-of-network .	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric <u>specialist</u> , nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty <u>provider</u> group, or by a physician assistant or nurse practitioner designated as primary care; a telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$35 / visit; \$20 / chiropractor visit; \$35 / acupuncture visit	20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit	<u>Deductible</u> applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; <u>cost share</u> waived for at least one mental health wellness exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	\$100 for hospitals; No charge for other <u>providers</u>	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a>	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	This <u>plan</u> uses the Blue Cross Blue Shield of Massachusetts Formulary - Focused; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$50 / retail supply or \$110 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 / admission	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	In-network <u>deductible</u> applies first for in-network and out-of-network services; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	In-network <u>deductible</u> applies first for in-network and out-of-network services
	<u>Urgent care</u>	\$35 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 / admission; \$700 / admission for certain hospitals	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$200 / admission for mental hospitals or substance abuse facilities; \$300 / admission for general hospitals; \$700 / admission for certain hospitals	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization 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 are pregnant	Office visits	No charge	20% <u>coinsurance</u>	Deductible applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$300 / admission; \$700 / admission for certain hospitals	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	\$20 / visit for outpatient services; No charge for inpatient services	20% <u>coinsurance</u> for outpatient services; 20% <u>coinsurance</u> for inpatient services	<u>Deductible</u> applies first except for in-network outpatient services; limited to 100 outpatient visits per calendar year (other than for autism, Down syndrome, <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>	\$20 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable
	<u>Skilled nursing care</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth, including supplies (20% <u>coinsurance</u> for out-of-network)

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)	
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; 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	20% <u>coinsurance</u> for members with a cleft palate / cleft lip condition	<u>Deductible</u> applies first for out-of-network; limited to members under age 18

**Excluded Services & Other Covered Services:**

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam every 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](http://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](http://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](http://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](http://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](http://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 1-800-932-8323 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** \$250
- **Delivery fee copay** \$0
- **Facility fee copay** \$300
- **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)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$610</b>

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

- **The plan's overall deductible** \$250
- **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)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

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

- **The plan's overall deductible** \$250
- **Specialist visit copay** \$35
- **Emergency room copay** \$100
- **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)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$450</b>

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

\* Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



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 option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from some preferred general hospitals, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at [bluecrossma.org/hospitalchoice](https://bluecrossma.org/hospitalchoice).

Left Blank Intentionally



MASSACHUSETTS

# HOSPITAL CHOICE COST SHARING

Your medical plan gives you an opportunity to control your share of medical costs for hospital care. What you pay depends on the hospital or related facility you choose.



## LOWER COST SHARE

Lower Cost Share (\$) applies to hospitals and related facilities that have met our quality benchmarks and are lower in cost. You pay less when you get care at these hospitals.



## HIGHER COST SHARE

Higher Cost Share (\$\$) applies to hospitals and related facilities that are higher in cost. You pay more when you get care at these hospitals.

## HOW HOSPITAL CHOICE COST SHARING WORKS

These costs apply to inpatient care, outpatient day surgery, outpatient high-tech radiology, outpatient diagnostic lab tests, outpatient diagnostic X-rays and other imaging tests, and outpatient short-term rehabilitation therapy.

This guide can help you get the highest value from your plan. Just follow the simple steps on the next page to review your hospitals and your options. Your health benefits will tell you what your specific share of the costs is. If you're not sure, you can call Member Service at the number on the front of your ID card.

### Questions?

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

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you'll pay different levels of cost share\* (such as copayments and/or co-insurance) for certain services depending on the network\* general hospital you choose to furnish those covered services. For most network general hospitals, you'll pay the lowest cost sharing level. However, if you receive certain covered services from some network general hospitals, you pay the highest cost-sharing level. A network general hospital's cost-sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost-sharing level will happen no more than once each calendar year. For help in finding a network general hospital for which you pay the lowest cost-sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at [myplans.bluecrossma.com/medical-insurance/hospital-choice-cost-sharing](http://myplans.bluecrossma.com/medical-insurance/hospital-choice-cost-sharing). Then click the Planning Guide link on the left of the screen to download a printable network hospital list, or to access the provider search page.

## FOLLOW THESE SIMPLE STEPS



### Step 1: Make a List of the Hospitals Where You Receive Care

In the table below, (highlight/circle/check off) the hospitals and clinics where you and your family go for care. Be sure to check which hospitals your doctors are affiliated with when you make your selections.



### Step 2: Find Out What You'd Pay at the Hospitals Where You Receive Care

Finding out whether your hospitals have a Lower or Higher Cost Share is easy:

- Visit the Hospital Choice Cost Sharing website at [bluecrossma.org/myblue/hospital-choice-cost-sharing](http://bluecrossma.org/myblue/hospital-choice-cost-sharing).
- Review the hospital list included with this document to check your hospitals.
- Call **1-888-636-4808**. Our specially trained Member Service associates are ready to help you review your current hospitals.



### Step 3: Choose Hospitals with a Lower Cost Share

If you go to Higher Cost Share hospitals, you might consider switching to Lower Cost Share hospitals. This will allow you to pay less every time you get care.

We can help you quickly and easily pick Lower Cost Share hospitals near where you live or work. Call Member Service at **1-888-636-4808**. You can also use our hospital search at the Hospital Choice Cost Sharing website: [bluecrossma.org/myblue/hospital-choice-cost-sharing](http://bluecrossma.org/myblue/hospital-choice-cost-sharing).

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

## HOSPITAL LIST

HOSPITAL NAME	CITY	STATE	MEMBER COST SHARE
Addison Gilbert Hospital	Gloucester	MA	Lower
Anna Jaques Hospital	Newburyport	MA	Lower
Athol Memorial Hospital	Athol	MA	Lower
Baystate Franklin Medical Center	Greenfield	MA	Lower
Baystate Medical Center	Springfield	MA	Higher
Baystate Wing Hospital	Palmer	MA	Lower
Berkshire Medical Center	Pittsfield	MA	Lower
Beth Israel Deaconess Hospital—Milton	Milton	MA	Lower
Beth Israel Deaconess Hospital—Needham Campus	Needham	MA	Lower
Beth Israel Deaconess Hospital—Plymouth	Plymouth	MA	Lower
Beth Israel Deaconess Medical Center	Boston	MA	Lower
Beverly Hospital	Beverly	MA	Lower
Boston Children's Hospital	Boston	MA	Higher
Boston Children's at Lexington	Lexington	MA	Lower
Boston Children's at Peabody	Peabody	MA	Lower

HOSPITAL NAME	CITY	STATE	MEMBER COST SHARE
Boston Children's at Waltham	Waltham	MA	Lower
Boston Medical Center	Boston	MA	Lower
Brigham and Women's Hospital	Boston	MA	Higher
Brigham and Women's/Mass General Health Care Center at Patriot Place	Foxborough	MA	Lower
Cambridge Health Alliance—Cambridge Campus	Cambridge	MA	Lower
Cambridge Health Alliance—Somerville Campus	Somerville	MA	Lower
Cambridge Health Alliance—Whidden Campus	Everett	MA	Lower
Cape Cod Hospital	Hyannis	MA	Higher
Clinton Hospital	Clinton	MA	Lower
Cooley Dickinson Hospital	Northampton	MA	Lower
Dana-Farber Cancer Institute	Boston	MA	Higher
Emerson Hospital	Concord	MA	Lower
Fairview Hospital	Great Barrington	MA	Higher
Falmouth Hospital	Falmouth	MA	Lower
Faulkner Hospital	Jamaica Plain	MA	Lower
Good Samaritan Medical Center	Brockton	MA	Lower
Harrington Memorial Hospital	Southbridge	MA	Lower
HealthAlliance Hospitals—Burbank Campus	Fitchburg	MA	Lower
HealthAlliance Hospitals—Leominster Campus	Leominster	MA	Lower
Heywood Hospital	Gardner	MA	Lower
Holy Family Hospital	Methuen	MA	Lower
Holy Family Hospital at Merrimack Valley	Haverhill	MA	Lower
Holyoke Medical Center	Holyoke	MA	Lower
Lahey Clinic	Burlington	MA	Lower
Lawrence General Hospital	Lawrence	MA	Lower
Lawrence Memorial Hospital	Medford	MA	Lower
Lowell General Hospital (includes the campus formerly known as Saints Medical Center)	Lowell	MA	Lower
Marlborough Hospital	Marlborough	MA	Lower
Martha's Vineyard Hospital	Oak Bluffs	MA	Lower
Mass General Cancer Center at Newton Wellesley	Newton	MA	Lower
Massachusetts Eye and Ear® Infirmary	Boston	MA	Lower
Massachusetts General Hospital	Boston	MA	Higher
Melrose-Wakefield Hospital	Melrose	MA	Lower
Mercy Medical Center	Springfield	MA	Lower
MetroWest Medical Center—Framingham Union	Framingham	MA	Lower
MetroWest Medical Center—Leonard Morse	Natick	MA	Lower
Milford Regional Medical Center	Milford	MA	Lower
Morton Hospital and Medical Center	Taunton	MA	Lower
Mount Auburn Hospital	Cambridge	MA	Lower

Continued

HOSPITAL NAME	CITY	STATE	MEMBER COST SHARE
Nantucket Cottage Hospital	Nantucket	MA	Lower
New England Baptist® Hospital	Boston	MA	Lower
Newton-Wellesley Hospital	Newton	MA	Lower
Noble Hospital	Westfield	MA	Lower
North Shore Center for Outpatient Care	Danvers	MA	Lower
North Shore Medical Center—Salem Campus	Salem	MA	Lower
Norwood Hospital	Norwood	MA	Lower
Saint Vincent Hospital	Worcester	MA	Lower
Shriners Hospitals for Children—Boston	Boston	MA	Lower
Shriners Hospitals for Children—Springfield	Springfield	MA	Lower
Signature Healthcare Brockton Hospital	Brockton	MA	Lower
South Shore Hospital	South Weymouth	MA	Lower
Southcoast Hospitals Group—Charlton Memorial Hospital	Fall River	MA	Lower
Southcoast Hospitals Group—St. Luke's Hospital	New Bedford	MA	Lower
Southcoast Hospitals Group—Tobey Hospital	Wareham	MA	Lower
Southwestern Vermont Medical Center	Bennington	VT	Lower
St. Anne's Hospital	Fall River	MA	Lower
St. Elizabeth's Medical Center	Brighton	MA	Lower
Sturdy Memorial Hospital	Attleboro	MA	Lower
Tufts Medical Center	Boston	MA	Lower
UMass Memorial Medical Center—Memorial Campus	Worcester	MA	Higher
UMass Memorial Medical Center—University Campus	Worcester	MA	Higher
Winchester Hospital	Winchester	MA	Lower



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).

Left Blank Intentionally

# BLUE CARE ELECT ENHANCED VALUE

SMHG

## TAP INTO YOUR HEALTH PLAN

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



Track claims  
and benefits



Find personalized  
care options



View your  
member ID card

### Get started

Sign in or create an account today. Download the app or visit [bluecrossma.org](http://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 are still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.*

## How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider on Find a Doctor at [bluecrossma.com/findadoctor](http://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](http://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 **\$500** per member (or **\$1,000** 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 maximum for medical benefits is **\$5,000** per member (or **\$10,000** per family) for in-network and out-of-network services combined.

Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** per family).

## Emergency Room Services

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

## Telehealth Services

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](http://bluecrossma.org), consult Find a Doctor, or call the Member Service number on your ID card.

## Your Virtual Care Team

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

## 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
<b>Preventive Care</b>		
Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> <li>Ten visits during the first year of life</li> <li>Three visits during the second year of life (age 1 to age 2)</li> <li>Two visits for age 2</li> <li>One visit per calendar year for age 3 and older</li> </ul>	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
Mental health wellness exams (at least one per calendar year)	Nothing	Nothing, no 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
<b>Outpatient Care</b>		
Emergency room visits	\$100 per visit (waived if admitted or for an observation stay)	\$100 per visit, no deductible (waived if admitted or for an 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"> <li>With a covered provider</li> <li>With the in-network designated telehealth vendor</li> </ul>	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 <ul style="list-style-type: none"> <li>Hospitals</li> <li>Other covered providers</li> </ul>	\$75 per category per service date Nothing	20% coinsurance after deductible 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"> <li>Office or health center services</li> <li>Ambulatory surgical facility, hospital outpatient department, or surgical day care unit</li> </ul>	\$25 per visit*** \$250 per admission	20% coinsurance after deductible 20% coinsurance after deductible
<b>Inpatient Care (including maternity care)</b>		
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission	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 or Down syndrome.

\*\* 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
<b>Prescription Drug Benefits*</b>		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	\$15 for Tier 1 \$30 for Tier 2 \$50 for Tier 3	Not covered
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	\$30 for Tier 1 \$60 for Tier 2 \$150 for Tier 3	Not covered

\* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.  
 \*\* Cost share may be waived, reduced, or increased for certain covered drugs and supplies.

**Get the Most from Your Plan: Visit us at [bluecrossma.org](http://bluecrossma.org) or call 1-800-932-8323 to learn about discounts, savings, resources, and special programs available to you, like those listed below.**

<b>Wellness Participation Program</b> 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
<b>Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program</b> (See your benefit description for details.)	\$150 per calendar year per policy
<b>Mind and Body Wellness Program</b> Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	\$300 per calendar year per policy

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

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-932-8323, or visit us online at [bluecrossma.org](http://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.

® Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

004691284 (4/26) JB

Left Blank Intentionally



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 <https://semhg.org/>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$0 in-network; \$500 member / \$1,000 family out-of-network.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For medical benefits, \$5,000 member / \$10,000 family; and for <u>prescription drug</u> benefits, \$1,000 member / \$2,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	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; <u>cost share</u> waived for at least one mental health wellness exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<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)	\$75 for hospitals; No charge for other <u>providers</u>	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a>	Generic drugs	\$15 / retail supply or \$30 / designated retail or mail service supply	Not covered	This <u>plan</u> uses the Blue Cross Blue Shield of Massachusetts Formulary — Focused; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$30 / retail supply or \$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	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 / 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
<b>If you need immediate medical attention</b>	<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)	\$500 / admission	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	\$500 / admission	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; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 / admission	20% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<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 for certain services
	<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, Down syndrome, <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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Children's glasses</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>Acupuncture (12 visits per calendar year)</li> <li>Bariatric surgery</li> <li>Chiropractic care</li> <li>Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine eye care - adult (one exam per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care (only for patients with systemic circulatory disease)</li> <li>Weight loss programs (\$150 per calendar year per policy)</li> </ul>

**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](http://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](http://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](http://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](http://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](http://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 1-800-932-8323 or contact your [plan](#) sponsor. (A [plan](#) sponsor is usually the member's employer or organization that provides group health coverage to the member.)

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

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

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

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

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

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

## About these Coverage Examples:



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

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

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

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

#### In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$560</b>

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

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

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

#### In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

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

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

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

#### 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
<b>The total Mia would pay is</b>	<b>\$200</b>

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

\* Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



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.

Left Blank Intentionally

# BLUE CARE ELECT SAVER

SMHG

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

## TAP INTO YOUR HEALTH PLAN

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



Track claims  
and benefits



Find personalized  
care options



View your  
member ID card

### Get started

Sign in or create an account today. Download the app or visit [bluecrossma.org](http://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

## 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) for in-network and out-of-network services combined. **The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.**

## When You Choose Preferred Providers

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

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

## How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider on Find a Doctor at [bluecrossma.com/findadoctor](http://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](http://bluecrossma.org)

## When You Choose Non-Preferred Providers

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

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

## Your Out-of-Pocket Maximum

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

## 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 in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

## Telehealth Services

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](http://bluecrossma.org), consult Find a Doctor, or call the Member Service number on your ID card.

## Your Virtual Care Team

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

## 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
<b>Preventive Care</b>		
Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> <li>Ten visits during the first year of life</li> <li>Three visits during the second year of life (age 1 to age 2)</li> <li>Two visits for age 2</li> <li>One visit per calendar year for age 3 and older</li> </ul>	Nothing, no deductible	20% coinsurance, no deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance, 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	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance, no deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance, no deductible
<b>Outpatient Care</b>		
Emergency room visits	\$50 per visit after deductible (copayment waived if admitted or for an observation stay)	\$50 per visit after deductible (copayment waived if admitted or for an observation stay)
Office or health center visits	Nothing after deductible	20% coinsurance after deductible
Mental health or substance use treatment	Nothing after deductible	20% coinsurance after deductible
Outpatient telehealth services <ul style="list-style-type: none"> <li>With a covered provider</li> <li>With the in-network designated telehealth vendor</li> </ul>	Same as in-person visit Nothing after deductible	Same as in-person visit Only applicable in-network
Chiropractors' office visits	Nothing after deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	Nothing after deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	Nothing after deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	Nothing after deductible	20% coinsurance after deductible
Diagnostic x-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia	Nothing after deductible	20% coinsurance after deductible
<b>Inpatient Care (including maternity care)</b>		
General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible

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

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
<b>Prescription Drug Benefits*</b>		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	After deductible \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3	After deductible \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	After deductible \$20 for Tier 1 \$50 for Tier 2 \$110 for Tier 3	Not covered

\* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.  
 \*\* Cost share may be waived, reduced, or increased for certain covered drugs and supplies.

**Get the Most from Your Plan: Visit us at [bluecrossma.org](http://bluecrossma.org) or call 1-800-932-8323 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

**Mind and Body Wellness Program**

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

\$300 per calendar year per policy

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

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-932-8323, or visit us online at [bluecrossma.org](http://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.

Left Blank Intentionally



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 <https://semhg.org/>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$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.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. In-network prenatal care; <u>preventive care</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	20% <u>coinsurance</u>	<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	20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit	<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	20% <u>coinsurance</u>	Limited to age-based schedule and / or frequency; <u>cost share</u> waived for at least one mental health wellness exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a>	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	\$10 / retail supply and all charges for mail service	This <u>plan</u> uses the Blue Cross Blue Shield of Massachusetts Formulary — Focused; <u>deductible</u> applies first; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	\$25 / retail supply and all charges for mail service	
	Non-preferred brand drugs	\$50 / retail supply or \$110 / designated retail or mail service supply	\$50 / retail supply and all charges for mail service	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$50 / visit	\$50 / 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	20% <u>coinsurance</u>	<u>Deductible</u> applies first; 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; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% <u>coinsurance</u>	<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	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	No charge 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; limited to 100 outpatient visits per calendar year (other than for autism, Down syndrome, <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	20% <u>coinsurance</u>	<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>Skilled nursing care</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	20% <u>coinsurance</u>	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	20% <u>coinsurance</u> for members with a cleft palate / cleft lip condition	Limited to members under age 18

## Excluded Services & Other Covered Services:

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

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

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam 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](http://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](http://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](http://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](http://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](http://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 1-800-932-8323 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 \$2,000
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

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
<b>The total Peg would pay is</b>	<b>\$2,070</b>

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

- The plan's overall deductible \$2,000
- Specialist visit copay \$0
- Primary care visit copay \$0
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

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
<b>The total Joe would pay is</b>	<b>\$2,720</b>

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

- The plan's overall deductible \$2,000
- Specialist visit copay \$0
- Emergency room copay \$50
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

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
<b>The total Mia would pay is</b>	<b>\$2,000</b>

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

\* Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



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.

Left Blank Intentionally



MASSACHUSETTS

# FIND A DOCTOR NEAR YOU

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

## THE EASY WAY TO FIND CARE



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



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



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

## HERE'S HOW TO START SEARCHING:

### For Current Members

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

### Not a Member Yet?

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

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

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

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

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

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

Left Blank Intentionally



MASSACHUSETTS

# DOCTORS ON CALL, ON YOUR DEVICE.

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



## REAL DOCTORS. REAL EXPERIENCE. REALLY FAST.



**GET MEDICAL CARE  
24/7**

Speak face to face with a doctor, in the privacy of your home.<sup>1</sup>



**THERAPY THAT  
COMES TO YOU**

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



**HIGHLY EXPERIENCED,  
HIGHLY RATED**

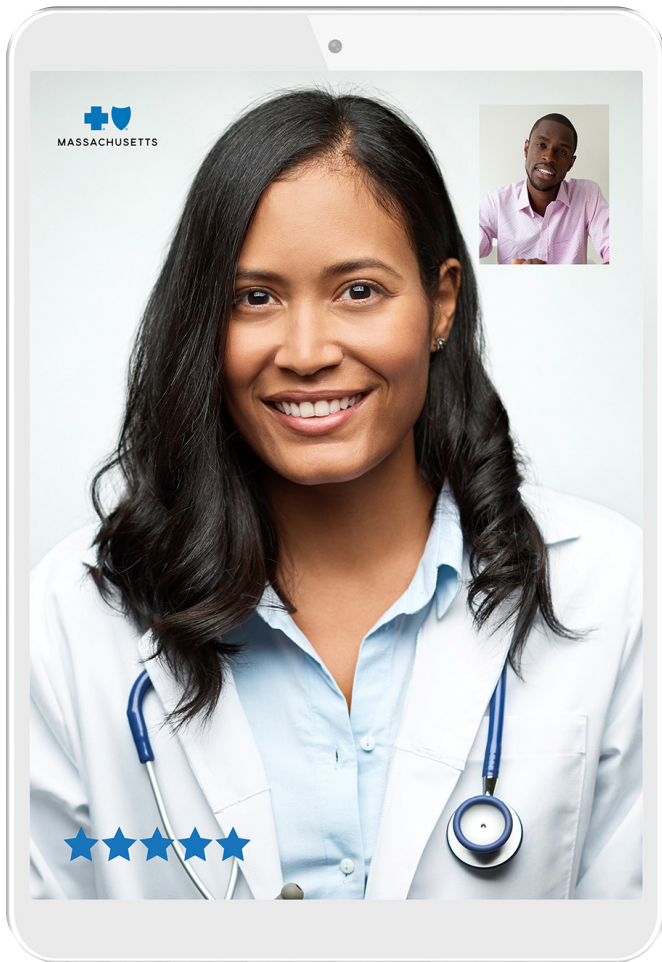
Qualified providers. Rated 4.8/5 stars and averaging 15 years of experience.<sup>2</sup>

### Sign In

Download the MyBlue App from the App Store<sup>®</sup> or Google Play<sup>™</sup>, or go to [bluecrossma.org](http://bluecrossma.org).

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

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



## IS A VIDEO DOCTOR VISIT RIGHT FOR ME?

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

### "I'm not feeling well."

Get care for:

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

### "I need emotional support."

Talk to a therapist about:

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

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

### "My loved one is under the weather."

If they're on your plan:

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



## WELL CONNECTION IS HIGHLY RATED: 4.8 out of 5 Doctor and Provider rating from our members<sup>3</sup>

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

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

4. Prescription availability is defined by doctor judgment.

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).

Left Blank Intentionally



MASSACHUSETTS

# GETTING CARE OUTSIDE THE UNITED STATES

Emergencies can happen unexpectedly during travel outside the United States. The Blue Cross Blue Shield network offers members access to doctors and hospitals around the world.



If members need care while traveling outside the U.S., they can call the **Blue Cross Blue Shield Global Core Service Center** at **1-800-810-BLUE (2583)**, or call collect at **1-804-673-1177, 24/7**. For help arranging a doctor's appointment or hospitalization if necessary. They can also visit **[bcbsglobalcore.com](https://www.bcbsglobalcore.com)**.

## Get the app



With the Blue Cross Blue Shield Global Core mobile app, world travelers have convenient access to doctors, hospitals, and resources around the world.

# SUBMITTING A CLAIM

## Inpatient care services

- When inpatient care is needed, members must call the **Blue Cross Blue Shield Global Core Services Center** at **1-800-810-2583** or call collect at **1-804-673-1177**.
- Global Core has a network of participating hospitals and provider referrals. We'll help members find providers and obtain authorization.
- Authorizations are required for out-of-country inpatient care. If a member is admitted as an inpatient to a facility, and authorization is not received at the time of the admission, medical records must be sent to Blue Cross Blue Shield of Massachusetts for review.
- In most cases, members shouldn't need to pay up front for inpatient care at a participating Global Core facility, except for the out-of-pocket expenses (non-covered services, deductible, copayment, and co-insurance).
- For members to avoid paying up front for inpatient care, cashless access needs to be arranged by Global Core. This process requires the timely completion of the Guarantee of Payment Form between Global Core and the facility.
- The facility should submit the claim on behalf of the member.
- Global Core must send medical information to Blue Cross Blue Shield of Massachusetts Health and Medical Management, for them to decide on the required inpatient authorization.
- If Global Core can't provide us with medical information before the member's discharge, the member will have to pay for the services and submit a claim to Global Core for payment.
- The member must complete (and sign) the **Global Core Claim Form** and attach an itemized statement.
- Members should try to obtain a copy of their medical records prior to discharge. Medical information will be needed for us to review for a post-service authorization.

## Outpatient care services

### (Plans with out-of-network benefits only)

- For outpatient visits to a provider or a hospital, members should show their ID card and pay at the time of service.
- Members are responsible for non-covered services, deductible, copayment, and co-insurance.
- For repayment, members must complete an **International Claim Form** and submit an itemized bill for reimbursement.
- Global Core receives the claim, interprets any documents (if necessary), and negotiates the foreign exchange rate to U.S. dollars.
- Global Core then forwards the claim for processing to Blue Cross Blue Shield of Massachusetts.
- If members want to be repaid via a check in U.S. currency, we'll issue the payment and corresponding Explanation of Benefits or Claim Summary.
- If members want to be repaid in foreign currency or in U.S. currency via a wire transfer, Global Core will issue the payment and Explanation of Benefits or Claim Summary.

The Blue Cross Blue Shield **Global Core Claim Form** (also called International Claim Form) is available at **bcbsglobalcore.com**. For security, a signature is needed on the claim form. Members can fill out the claim online, print it, sign it, scan it, and email it to **claims@bcbsglobalcore.com**. This email address is listed on the form.

They can also mail the claim to:

**Service Center**  
**PO Box 2048**  
**Southeastern, PA 19399**

## MEMBER OUT-OF-COUNTRY COVERAGE LETTERS

Members can request out-of-country coverage letters, indicating the coverage they have available while outside the U.S., by calling the Member Service number on the back of their ID card.

## MEDICAL EVACUATION OR REPATRIATION

None of our policies provides benefits for medical evacuation or repatriation (return to the home country).

<b>Emergency medical evacuation</b>	When a member needs to be removed from a region. In most cases, evacuation is not to a person's home, but to the nearest qualified medical facility.
<b>Emergency reunion</b>	When a friend or family member is reunited with a patient for medical evacuation. These non-covered services may include airfare, accommodation, and living expenses.
<b>Return of mortal remains or repatriation of remains</b>	The cost of returning a body to the home country if a person dies while abroad.

Trips are meant to be enjoyed. That's why we offer our members worldwide health care solutions with world-class service along the way.

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).

Left Blank Intentionally

# A WHOLE NEW WAY TO DO PRIMARY CARE

## Your Virtual Care Team is here

An innovative way to do primary care that's convenient and comprehensive is here. You can now choose a virtual primary care provider (PCP) to lead your new Virtual Care Team.\*



## PRIMARY CARE THAT'S A PRIME EXPERIENCE

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



### CONVENIENT

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



### COMPREHENSIVE

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



### COORDINATED

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

## LEARN MORE

For more information, sign in to your MyBlue account at [bluecrossma.org](http://bluecrossma.org).

# HERE'S HOW IT WORKS

START BY PICKING  
YOUR VIRTUAL PCP



ENJOY MORE  
CONVENIENT CARE



GET THE BEST  
OF BOTH WORLDS



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

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

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

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

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

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

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

Left Blank Intentionally



MASSACHUSETTS

# HEALTH SAVINGS ACCOUNTS

## Control, Flexibility, and Peace of Mind

Your health plan includes an option for you to open a Health Savings Account (HSA). Setting up an HSA with your Blue Cross Blue Shield of Massachusetts Saver plan is a great way to control and plan for your health care expenses, now and in the future. It gives you the freedom to manage how you save and spend your health care dollars.



### What is an HSA?

An HSA allows you to set aside tax-free dollars that you can save for medical expenses today, tomorrow, and even for retirement.

### How does an HSA work?

The HSA works a lot like a savings account that you use to pay for qualified health care expenses. Money is deposited into the account, and you can spend it when you need it.

Because your health plan has a deductible, the HSA is a great way to set aside funds to minimize your out-of-pocket costs when you get care.

You can use the HSA to pay for qualified medical expenses, such as:

- Qualified medical, dental, and vision services
- Deductibles
- Copayments
- Co-insurance

You can also use the HSA funds for some qualified expenses that aren't covered by traditional health plans, such as laser eye surgery. However, if you use the HSA funds for non-qualified services, you'll be responsible for taxes and a penalty.

## Sign In

Visit [myblue.bluecrossma.com](https://myblue.bluecrossma.com) to create an account, or download the app from the App Store® or Google Play™.



### What are the advantages of an HSA?

An HSA allows you to put money aside for health care expenses, control the funds, and enjoy the benefits of:

- Pre-tax contributions—These reduce your taxable income. For example, if you're in the 30 percent federal tax bracket and contribute \$100 each month to your HSA, your taxable income will decrease by \$100, saving you \$30 in taxes.
- Tax-free growth—Earn interest and build savings tax-free
- Tax-free withdrawals—For qualified medical expenses
- Portability—The funds stay with you if you change employers
- Control—Decide for yourself whether to spend or save
- Investment flexibility—Help your money grow by investing in mutual funds and other securities (check with your HSA administrator for investment rules)
- Retirement savings—Similar to an IRA, you can make tax-free contributions to your HSA. However, unlike an IRA, withdrawals from your HSA are tax-free when you withdraw money from your HSA after the age of 65 for qualified medical expenses.

### Can I use an HSA to build health care savings?

The money in your HSA is yours, and you control the account. If you leave your employer, your account goes with you and any unused funds roll over from year to year.

This means you can save funds for use in future years—even in retirement. And, you can invest the money to help it grow (see your HSA administrator for specifics on investing).

### How much can I contribute to my HSA?

You can fund an HSA within the annual limits set by the Internal Revenue Service:

Maximum HSA Contribution <sup>1</sup>	Individual	Family
2026	\$4,400	\$8,750
2025	\$4,300	\$8,550

1. Adjusted annually for inflation. If you're age 55 or older, you can make additional "catch-up" contributions. The "catch-up" contribution limit for 2025 and 2026 is \$1,000.

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).

Left Blank Intentionally



## START SAVING TODAY

with exclusive discounts just for Blue Cross Blue Shield members.

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

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

Enjoy one-of-a-kind discounts on:



**Fitness Gear & Apparel**



**Gym Memberships**



**Hearing Aids**



**Nutrition**



**Vision Care**

**...And much more!**

Sign up for free today by visiting [Blue365deals.com](https://Blue365deals.com) or scan the code:



MASSACHUSETTS

Blue365

© 2025 Blue Cross and Blue Shield Association — All Rights Reserved. The Blue365 program is brought to you by the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association is an association of independent, locally operated Blue Cross and/or Blue Shield Companies. Blue365 offers access to savings on health and wellness products and services and other interesting items that Members may purchase from independent vendors, which are not covered benefits under your policies with Blue Cross and Blue Shield of Texas, its contracts with Medicare, or any other applicable federal health care program. These products and services will be offered to you through the entire benefit year. During the year, the independent vendors may offer additional discounts on these products and services. To find out what is covered under your policies, contact Blue Cross and Blue Shield of Massachusetts. The products and services described on the Site are neither offered nor guaranteed under your Blue Cross and Blue Shield of Massachusetts's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding your health insurance products and services may be subject to your Blue Cross and Blue Shield of Massachusetts's grievance process. BCBSA may receive payments from vendors providing products and services on or accessible through the Site. Neither BCBSA nor any Blue Company recommends, endorses, warrants, or guarantees any specific vendor, product or service available under or through the Blue365 Program or Site.

Left Blank Intentionally

# SUPPORT FOR YOUR MATERNITY JOURNEY

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



## Maternity Care Management

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



## Breast Pump Savings

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



## Childbirth Course Reimbursement

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



## Maternal Mental Health Support

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



## Lactation Consultations

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



## 24/7 Nurse Line

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

## Learn More

To see all your maternity benefits in one place, visit [bluecrossma.org/maternity](https://bluecrossma.org/maternity).

## MYBLUE IS HERE TO HELP

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



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



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).

Left Blank Intentionally



MASSACHUSETTS

# GET YOUR NO-COST FLU SHOT

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



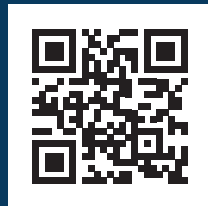
## WHERE TO GET YOUR SHOT

The flu shot is available at no additional cost<sup>2</sup> from in-network providers and locations, like a primary care provider or pharmacy. To find an in-network provider or location near you, go to [bluecrossma.com/findadoctor](https://bluecrossma.com/findadoctor).



## LEARN MORE

Just about everyone six months and older should get the annual flu shot.<sup>1</sup> Learn more about the flu and the flu shot at [bluecrossma.org/flu](https://bluecrossma.org/flu).



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

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

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).

Left Blank Intentionally



MASSACHUSETTS

# TAKE ADVANTAGE OF OUR BEHAVIORAL HEALTH CARE RESOURCES



Behavioral health conditions can be difficult to identify and treat. That’s why Blue Cross Blue Shield of Massachusetts offers behavioral health case management programs and behavioral health visits through Well Connection. These simple and effective resources are designed to help if you or a family member is struggling with a behavioral health condition.

## YOU CAN USE WELL CONNECTION FOR:

Depression  
Anxiety  
Sleep disorders

Child behavior  
Substance use disorders  
Trauma  
Bereavement

Couples therapy  
Stress  
Emotional impact of divorce

## Questions?

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

## GET PERSONALIZED CARE WITH BEHAVIORAL HEALTH CASE MANAGEMENT

Management programs for behavioral health conditions are designed to support the care you receive from your doctor, and are available at no additional cost.

Our case managers work together with your doctor to ensure you get the care you need—and that it's cost effective.

### OUR CASE MANAGEMENT PROGRAMS INCLUDE:

#### Continuity of Care Program

After a discharge from a behavioral health inpatient facility, one of our case managers will reach out to make sure that you understand your aftercare plan instructions. Reviewing the plan together may reduce the risk of being readmitted to the hospital.

#### Complex Behavioral Management Program

This program provides ongoing support and helps manage chronic behavioral health conditions.

#### Depression Case Management Program

For those who have been diagnosed with depression, this program provides educational resources to help manage symptoms.

#### Substance Use Disorder Program

This program is designed for those who are recovering from a drug or alcohol use disorder. We work together with inpatient facilities in Massachusetts to help members maintain recovery, identify any barriers or gaps in care, provide education about the disease and treatment options, and offer support in following a treatment plan.



### HOW TO ENROLL

If you're identified—by us or by a doctor—as someone who may benefit from one of these programs, we'll reach out to you by mail or by phone. To find out if you're eligible for the behavioral health case management program, call **1-888-883-8970**, Monday through Thursday, 8:30 a.m. to 8:00 p.m. and Friday, 8:30 a.m. to 4:30 p.m. ET.

## USE WELL CONNECTION ANYTIME, ANYWHERE

Well Connection lets you see licensed doctors and providers using live video visits on your smartphone, tablet, or computer. You can schedule appointments and see behavioral health professionals anywhere in the United States, whether at home, at work, or on vacation. It's a simple, convenient way to get care.

## HOW IT WORKS



Download the app, or visit [wellconnection.com](https://www.wellconnection.com)



Create an account or sign in



Select Behavioral Health



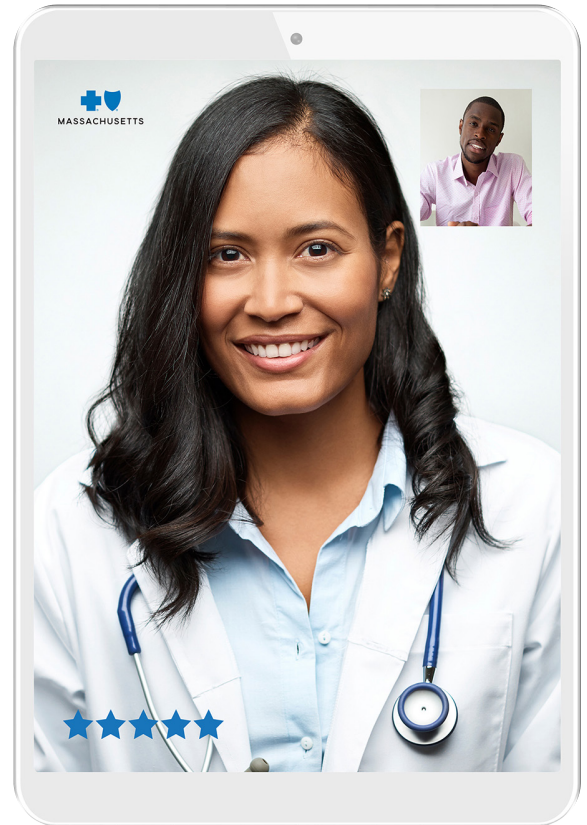
Schedule an appointment

Once you've set up an appointment, simply sign in to Well Connection before the scheduled time to start the visit.



Highly experienced, highly rated

Qualified practitioners. Rated 4.8/5 stars and averaging 15 years of experience.\*



## ADDITIONAL RESOURCES

Whether you need to find a therapist or just have questions about your health, take advantage of these additional resources.

### Find a Doctor

You can use our **Find a Doctor & Estimate Costs tool** to search for behavioral health professionals by name, specialty, or location. You can even search for providers who offer video visit services. Follow these simple steps:

1. Go to [bluecrossma.com/findadoctor](https://www.bluecrossma.com/findadoctor) and sign in.
2. Select **Medical Care**, and then **Behavioral Health**.
3. Choose the type of care you want to search for.

### 24/7 Nurse Line

If you have questions about your health, you can talk to a professionally trained, registered nurse 24 hours a day, 7 days a week. The 24/7 Nurse Line is a quick way to get your questions answered and find out your options for getting care.

### ahealthyme®

You can visit **ahealthyme** for behavioral health articles, risk assessments, and support. Read about the latest behavioral health news or get information on common conditions by going to [ahealthyme.com](https://www.ahealthyme.com), and then selecting **Behavioral Health** in the drop-down menu under **Health Centers**.

## Questions?

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



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).

Left Blank Intentionally



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](https://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](http://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 __/__/__
<b>Claim is for (choose one and color in the entire box):</b> <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): _____	<b>Name, Address, and Phone Number of Qualified Fitness Expense</b>		
	<b>Total Dollars requested for Qualified Fitness Expense: \$ _____</b> <b>Calendar year that fees were paid: _____</b>		

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).

Left Blank Intentionally



MASSACHUSETTS

# LOSE WEIGHT, GAIN SAVINGS

Stay motivated and get up to \$150 annually for participating in a qualified weight-loss program.<sup>1</sup>



## Qualifies for weight-loss reimbursement

- Hospital-based programs and Weight Watchers<sup>®</sup> 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



## Doesn't qualify 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, complete the attached form.

3

### Mail

Send the completed form to the address listed.

You can also sign in to MyBlue to submit the form at [member.bluecrossma.com/login](https://member.bluecrossma.com/login).

Be sure to check with your primary care provider before starting any weight-loss program.

## Questions?

Call Team Blue Member Service at the number on your ID card.

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



MASSACHUSETTS

# WEIGHT-LOSS REIMBURSEMENT REQUEST

Please print clearly.

To verify this reimbursement is offered within your plan, or for more information, sign in to MyBlue at [bluecrossma.org](http://bluecrossma.org) or call Team Blue Member Service at the number on your ID card. All weight-loss 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 (MM/DD/YY)
Claim is for (choose one and color in the entire box):			
<input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Ex-spouse <input type="checkbox"/> Other (specify) _____			
<input type="checkbox"/> Spouse (of policyholder) <input type="checkbox"/> Dependent (up to age 26)			
Name, address, and phone number of qualified weight-loss program:			
Total dollars requested: \$ _____			Year fees paid:
Monthly program participation fee: \$ _____			

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within thirty 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 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 weight-loss program to Blue Cross Blue Shield of Massachusetts.

Subscriber signature:	Date (MM/DD/YY)
-----------------------	-----------------

### Complete this form and mail it to:

Blue Cross Blue Shield of Massachusetts Local Claims Department  
P.O. 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).

Left Blank Intentionally

# MIND AND BODY REIMBURSEMENT

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

Save up to

# \$300

per family per calendar year.



## Qualified for Mind and Body Reimbursement:

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



## Not Qualified for Mind and Body Reimbursement:

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

## Find a Qualified Provider and Save

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

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

## GET REIMBURSED IN THREE EASY STEPS

# 1

### Choose

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

# 2

### Complete

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

# 3

### Mail

Send the completed form to the address listed.

## Questions?

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

# MIND AND BODY REIMBURSEMENT REQUEST

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

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

## Subscriber Information (Policyholder)

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

## Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth __/__/__
--------------------	------------	----------------	---------------------------

Claim is for (choose one and color in the entire box):

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

Name, Address, and Phone Number for Qualified Expense (Service or App)

Total dollars requested: \$ \_\_\_\_\_

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 you should consult your tax advisor.

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

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

Subscriber's or Member's Signature: \_\_\_\_\_

Date: \_\_/\_\_/\_\_

### Important Information:

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

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

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).

Left Blank Intentionally

# Worldwide Coverage

For Foreign and Domestic Travelers



Get quality health care no matter where you are in the world.

Whether you're traveling within the United States or abroad, BlueCard<sup>®</sup> and Blue Cross Blue Shield Global<sup>®</sup> Core make sure you have access to top doctors and hospitals and concierge-level service.

---

Call **1-800-810-BLUE (2583)** for a list of participating doctors and hospitals, or to obtain an international claim form.



Take this reference card with you when you travel.

When you need care, you'll be prepared.

TEAR HERE

## Urgent Care

1. Call **1-800-810-BLUE (2583)**, or visit **bcbs.com** to find nearby doctors and hospitals anywhere in the world that participate in the Blue Cross Blue Shield network.
2. Show your member ID card when you get care.
3. If you're admitted, or if you have questions about your coverage, call Member Service at the number on the front of your ID card.

## Your Passport to Good Health

Always carry your Blue Cross Blue Shield of Massachusetts ID card.

FOLD HERE

## Emergency Care


For emergency services, call the local emergency number or go to the nearest hospital immediately.

## Getting Care in the United States

More than 85 percent of all doctors and hospitals in the United States participate in the BlueCard program. If you need care outside your plan's service area, call **1-800-810-BLUE (2583)**, or visit **bcbs.com** to find a doctor near you. Be sure to show your ID card before you receive service.

### When you get service:

- There's no paperwork
- Participating doctors and hospitals submit claims for you
- All you pay is the copayment, co-insurance, or deductible
- If you receive care from a non-participating doctor or hospital, you may need to pay for the services up front and submit a claim for reimbursement

**BlueCard PPO Members Only:** If you see this symbol, , on your ID card, you're a BlueCard PPO member. To save the most money when getting service, use a participating BlueCard PPO doctor or hospital.

## In Case of Emergency

For emergency services, call the local emergency number or go to the nearest hospital immediately.

## Getting Care Outside the United States

The Blue Cross Blue Shield Global<sup>®</sup> Core network gives you access to doctors and hospitals around the world. If you need care, call the Service Center at **1-800-810-BLUE (2583)**, or call collect at **1-804-673-1177**, 24 hours a day, 7 days a week. An assistance coordinator, along with a medical professional, will arrange a doctor's appointment or hospitalization if necessary. You can also visit **bcbsglobalcore.com**.

TEAR HERE



An Association of Independent Blue Cross and Blue Shield Plans

FOLD HERE

Primary Care Provider's Name: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Doctor's Hospital Affiliation: \_\_\_\_\_

Your Blue Cross Blue Shield Member ID: \_\_\_\_\_

Member Service Phone Number (from your ID card): \_\_\_\_\_

## For Inpatient Services:

- Call the Service Center at **1-800-810-BLUE (2583)**, or Member Service at the number on your ID card, for precertification or preauthorization
- In most cases, all you pay is the copayment, co-insurance, or deductible
- The hospital should submit the claim on your behalf

## For Outpatient Services:

- Show your ID card
- Pay the doctor or hospital
- Fill out a Blue Cross Blue Shield Global<sup>®</sup> Core International Claim form for reimbursement (Call **1-800-810-BLUE (2583)** or visit **bcbsglobalcore.com** for the form)
- You're only responsible for copayments, co-insurance, or deductible when seeing in-network doctors and hospitals
- You'll pay more when seeing out-of-network doctors and hospitals

## Doctors and Hospitals

In most cases, participating doctors and hospitals will file the claim for you. If they need information about eligibility or your coverage, have them call **1-800-676-BLUE (2583)**.

## Your Member Responsibilities

As a Blue Cross Blue Shield of Massachusetts member, you're still responsible for any copayments, co-insurance, deductible, or non-covered services. For out-of-country services, Blue Cross Blue Shield of Massachusetts payments will be based on the provider's charge.

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**).

Left Blank Intentionally



MASSACHUSETTS

# OUR COMMITMENT TO CONFIDENTIALITY (NOTICE OF PRIVACY PRACTICES) AND WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

This notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Our Commitment: We respect your right to privacy. We will not disclose personally identifiable information about you without your permission, unless the disclosure is necessary to provide our services to you or is otherwise in accordance with the law.**

## Collection of Information

We collect only the information about you that we need to operate our business. We collect information from other parties, such as your health care providers and employers. Examples of the information we collect are (i) medical and dental information from health care providers when they submit claims for services and (ii) personal information such as name, address, and date of birth, which is most often supplied by you or your employer when you enroll in a plan.

## USE AND DISCLOSURE OF INFORMATION

We are required by law to protect the confidentiality of information about you and to notify you in case of a breach affecting your information. We may use and disclose information about you without your written authorization for the following purposes, to the extent otherwise permitted or required by law:

**You or Your Representatives**—to you or your “personal representative” upon request or to help you (or your personal representative) understand treatment options, benefits, or the rights available to you. Your “personal representative” is a person who has legal authority to make health-related decisions on your behalf, such as a person with a health-care power of attorney. Your request must be in writing. Please complete the Documentation of Legal Representative Status for Members form available on our website. You also may designate a family member or friend to receive information and interact with us on your behalf. Your designation and any subsequent revocation must be in writing. Please complete the Member’s Designation of an Authorized Representative form available on our website. You may also call Member Service for a copy of these forms.

- **Treatment**—to help health care providers manage or coordinate your health care and related services. For example, we may use and disclose information about you to inform providers of medications you take or to remind you of appointments.
- **Payment**—to obtain payment for your coverage, pay claims for your health benefits, or help another health plan or health care provider in its payment activities. For example, we may use or disclose information about you to make coverage determinations, administer claims, or coordinate benefits with other coverage you may have.
- **Health Care Operations**—to perform other activities necessary for the operation of our business, including customer service, disease management, and determining how to improve the quality of care. For example, we may use or disclose information about you to respond to your call to customer service, arrange for medical review of your claims, or conduct quality assessment and improvement activities.

- **Legal Compliance**—to comply with applicable law. For example, we may be required to use or disclose information about you to respond to regulatory authorities responsible for oversight of government benefit programs or our business operations; to parties or courts in the course of judicial or administrative proceedings; or pursuant to workers' compensation laws.
- **Government Agencies**—under limited circumstances established by law, to public health authorities, coroners or medical examiners, law enforcement, or other government officials
- **Research**—for health-related research studies that meet legal standards for protection of the individuals involved in the studies and their personal information. We may also create a database of our members' information that does not include individual identifiers and use the database for research or other purposes, provided that the information cannot be traced back to specific members.
- **To Your Employer** (or other plan sponsor), if applicable, for administration of its health plan. This applies only if you receive coverage through an employer-sponsored plan (or plan sponsored by your union or other entity). For example, we may disclose information about you to your employer (or other plan sponsor) to confirm

enrollment in the plan or (if the employer or other plan sponsor is self-insured) for claim review and audits. We will disclose your information only to designated individuals. That, along with legal prohibitions on use of your personal information for discriminatory purposes, helps protect your information from unauthorized use.

To carry out these purposes, we share information with entities that perform functions for us subject to contracts that limit use and disclosure for intended purposes. We use physical, electronic, and procedural safeguards to protect your privacy. Even when allowed, we limit uses and disclosures of your information to the minimum amount reasonably necessary for the intended task.

The Health Insurance Portability and Accountability Act (HIPAA) generally does not override other laws that give people greater privacy protections. As a result, we must comply with any state or federal privacy laws that require us to provide you with more privacy protections. For example, federal law provides special protections for substance use disorder information; Massachusetts state law restricts the disclosure of HIV and AIDS related information. In addition, we will not use (and are prohibited from using) your genetic information for underwriting purposes.

---

## OTHER DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION

Except as provided in this notice, we will not use or disclose information about you without your written authorization. For example, we must have your written authorization to use or disclose your information for marketing purposes or (in most cases) to use or disclose psychotherapy notes. Although we would need written authorization to sell information about you, we do not sell members' information.

You may revoke your authorization at any time. Your authorization must be in writing. Your revocation will not affect any action that we have already taken in reliance on your authorization. If you would like us to disclose information about you to a third party, please complete the Permission for One-Time Disclosure of Information form available on our website or call Member Service for a copy of the form.

---

## YOUR PRIVACY RIGHTS

You have the following rights with respect to information about you. You may exercise any of these rights by calling the Member Service number listed on your member ID card or contacting us at the address listed at the end of this notice. The forms listed below are also available on our website.

- **You have the right to receive information about privacy protections.** Your member-education materials include a notice of your rights, and you may request a paper copy of this notice at any time.
- **You have the right to inspect and get copies of information that we use to make decisions about you.** This is your designated record set. Your request must be in writing. We may charge a reasonable fee for copying and mailing you this information. Please complete the Request for Access to Copies of Protected Health Information in Designated Record Set form to request copies of your information.
- **You have the right to receive an accounting of certain disclosures that we make of information about you.** Your request must be in writing. Please complete the Members Request for an Accounting of Disclosures form. Our response will exclude any disclosures made in support of treatment, payment, and health care operations or that you authorized (among others). An example of a disclosure that would be reported to you is our disclosure of your information in response to a court order.
- **You have the right to ask us to correct or amend information you believe to be incorrect.** Your request to correct or amend information must be in writing. Please complete the Members Request to Amend Protected Health Information form. If we deny your request, you may ask us to make your request part of your records.

- **You have the right to ask that we restrict or refuse the disclosure of information about you and that we direct communications to you by alternative means or to alternative locations.** While we may not always be able to agree to your request, we will make reasonable efforts to accommodate requests. Unless you've notified us to request a different mailing address, Summary of Health Plan Payments statements for the subscriber, and all members listed on the subscriber's plan, are generally delivered to the subscriber's address. Under certain circumstances, you can request to not receive statements for a particular service, or to have statements delivered through an alternate method or to an alternate address, when required by state law. If you have concerns about protecting the privacy of your medical information in your

statements, you can have these statements delivered to an address other than the plan subscriber's address, or have them delivered only via electronic means. For help understanding your delivery options, please call Member Service at the number listed on your member ID card. Your request and any subsequent revocation must be in writing.

If you believe your privacy rights have been violated, you have the right to complain to us using the grievance process outlined in your benefit materials, or to the Secretary of the U.S. Department of Health and Human Services, without fear of retaliation.

---

## ABOUT THIS NOTICE

The original effective date of this notice was April 14, 2003. The effective date of the most recent revision is indicated in the footer of this notice. We are required by law to provide you with this notice of our legal duties and privacy practices and to abide by the notice for as long as it is in effect. We reserve the right to change this notice. Any changes will apply to all information that we maintain, regardless of when it was created or received. If we make a material change to this notice, we will post the revised notice on our website and notify you of the change and how to obtain the revised notice in our next regular mailing to you. If you have any questions, please call the Member Service number listed on your member ID card, or write us at:

**Blue Cross Blue Shield of Massachusetts**  
**Privacy Officer**  
**101 Huntington Ave.**  
**Suite 1300**  
**Boston, MA 02199-7611**

## WHCRA NOTICE

Did you know that your medical plan provides benefits for many mastectomy-related services? This is the case even if you were not covered by Blue Cross Blue Shield of Massachusetts at the time of the mastectomy. It's required by the Women's Health and Cancer Rights Act of 1998. If you are covered for a mastectomy and elect breast reconstruction in connection with a mastectomy, then benefits are also provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage will be provided as determined in consultation with you and your attending doctor. The costs that you pay for these services are the same as those you pay for other services in the same category. To learn more, please call the Member Service number on your member ID card.

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

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

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**).

® Registered Marks of the Blue Cross and Blue Shield Association. © 2021 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Left Blank Intentionally

# Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

## Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

## Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

## Balance Billing

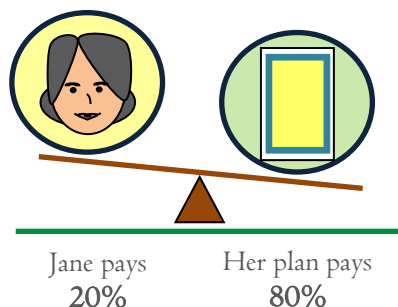
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not balance bill you for covered services.

## Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

## Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

## Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

## Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called “copay”). The amount can vary by the type of covered health care service.

## Cost Sharing

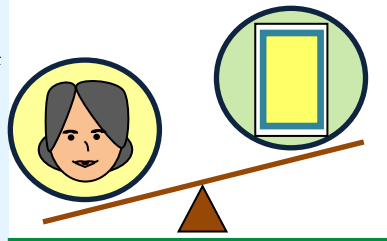
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

## Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

## Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100%      Her plan pays 0%  
(See page 6 for a detailed example.)

## Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

## Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

## Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

## Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

## Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

## Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

## Grievance

A complaint that you communicate to your health insurer or [plan](#).

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

## Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

## In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

## Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

## Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

## Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

## Minimum Essential Coverage

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](#).

## Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

## Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

## Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

## Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

## Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

## Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

## Out-of-network Provider (Non-Preferred Provider)

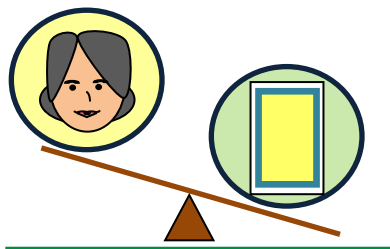
A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

## Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for

health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



Jane pays 0%      Her plan pays 100%

(See page 6 for a detailed example.)

## Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

## Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “[health insurance](#).”

## Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

## Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

## Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

## Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each “tier” of covered [prescription drugs](#).

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

## Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

## Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

## Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

## Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

## Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

## Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

## Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

## Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

## Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

# How You and Your Insurer Share Costs - Example

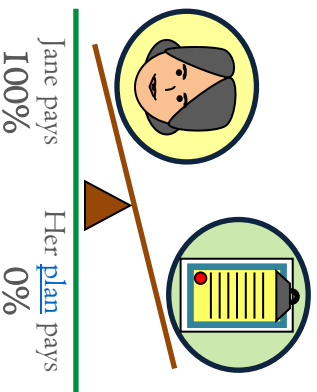
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>  
Beginning of Coverage Period

December 31<sup>st</sup>  
End of Coverage Period



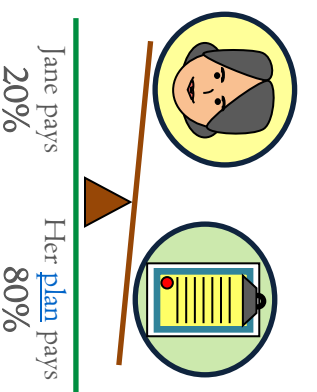
**Jane hasn't reached her \$1,500 deductible yet**

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



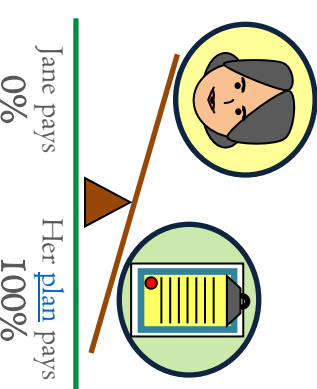
**Jane reaches her \$1,500 deductible, coinsurance begins**

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



**Jane reaches her \$5,000 out-of-pocket limit**

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125

**PR A Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PR A Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

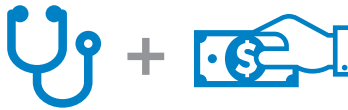
Left Blank Intentionally

# A Guide to Your Summary of Health Plan Payments<sup>1</sup>

The Summary of Health Plan Payments shows you how we process claims for medical services you've received. This statement is not a bill.

## How the Payment Process Works

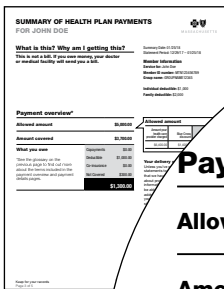
When you visit a health care provider, you pay a copayment.<sup>2</sup>



The provider submits a bill for services to Blue Cross. This is called a claim.



You'll get a Summary of Health Plan Payments if there's a balance remaining after we process the claim and pay our share of the costs. Your provider will send you a bill if you owe any money.



### Payment overview\*

<b>Allowed amount</b>	<b>\$5,000.00</b>
<b>Amount covered</b>	<b>\$3,700.00</b>
<b>Amount covered you owe by Blue Cross</b>	
Copayments	\$0.00
Deductible	\$1,000.00
Co-insurance	\$0.00
Not Covered	\$300.00
<b>Total</b>	<b>\$1,300.00</b>

**This is not a bill.**

### Copayments

Your copayments (also known as a copay) are the fixed dollar amount you pay each time you see a provider<sup>2</sup> or fill a prescription. Look for your copay amount on your member ID card.

### Deductible

If your plan has a deductible, this is the amount of money you pay out-of-pocket for health care services, such as blood tests and x-rays, before Blue Cross starts to pay for them.

### Co-insurance

If your plan has co-insurance, you're responsible for paying a predetermined percentage of your medical expenses once your deductible has been met.

### Amount covered you owe by Blue Cross

\*See the glossary on the previous page to find out more about the terms included in the payment overview and payment details pages.

### Amount you owe (if any)

**Tip:** See the glossary on page 2 of your statement for the meaning of any unfamiliar terms.



The provider sends you a bill. (if you owe money)



You pay your provider.



## Financial accounts can help cover costs.

If your plan has a Health Reimbursement Arrangement, Health Savings Account, or Flexible Spending Account, you can use it to pay medical expenses, such as your deductible and copayments. You can also use these accounts to pay for eyeglasses and dental services.

1. Medex members receive statements called Explanation of Benefits.

2. Except for certain plans, preventive services are fully covered. Some plans may require co-insurance.




# Your Summary of Health Plan Payments

## Payment Overview Page

### SUMMARY OF HEALTH PLAN PAYMENTS FOR JOHN DOE

**What is this? Why am I getting this?**

**This is not a bill. If you owe money, your doctor or medical facility will send you a bill.**



MASSACHUSETTS

Summary Date: 01/25/18  
Statement Period: 12/29/17 – 01/25/18

**Member Information**  
**Service for:** John Doe  
**Member ID number:** MTN123456789  
**Group name:** GROUPNAME12345

**Individual deductible:** \$1,000  
**Family deductible:** \$2,000

**Allowed amount**

Amount your health care provider charged	Blue Cross discount	Allowed amount
\$6,400.00	\$1,400.00	<b>\$5,000.00</b>

**Your delivery options**

Unless you've notified us, we typically deliver statements to the subscriber's address that we have on file. If you have concerns about protecting the privacy of your medical information in these statements, you may be able to have them delivered to a different address. Under certain circumstances, you can also request to not receive these statements for a particular service.

For help updating your delivery preferences, please call Member Service at the number on the front of your ID card, Monday through Friday, from 8:00 a.m. to 6:00 p.m. ET.

**Payment overview\***

<b>Allowed amount</b>	<b>\$5,000.00</b>
<b>Amount covered</b>	<b>\$3,700.00</b>
<b>What you owe</b>	
Copayments	\$0.00
Deductible	\$1,000.00
Co-insurance	\$0.00
Not Covered	\$300.00
	<b>\$1,300.00</b>

\*See the glossary on the previous page to find out more about the terms included in the payment overview and payment details pages.

Keep for your records (For a detailed breakdown of your payments, please see page 5) ▶

Page 3 of 5

- A

The payment overview shows the amount charged to Blue Cross, the amount we covered, and what you owe (if anything).
- B

Up here, you'll find your account information, including your plan's deductible. A deductible is the amount you pay for medical services before your insurance begins to pay.
- C

This section shows how the allowed amount was calculated.
- D

Your delivery options describes how these statements are delivered and how you can update your preferences.

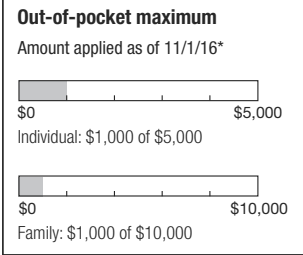
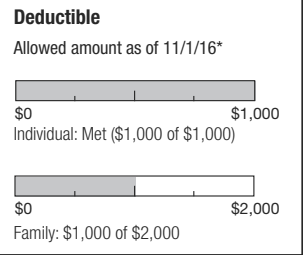


# Your Summary of Health Plan Payments

## Payment Details Page

HEALTH PLAN PAYMENT DETAILS							F	G					H
							Breakdown of what you owe						
Service date	Service type	Amount charged			Other insurance	Amount covered	What you owe	Copayments	Deductible	Co-insurance	Not covered (see notes)	What you owe	See notes
		Amount your health care provider charged	Blue Cross discount	Allowed amount									
<b>Dr. Josephine Smith, ABC Hospital Patient Name: John Doe Claim #: 11111111111111 (In-Network)</b>													
1/15/18	Routine Services	\$400.00	-\$180.00	\$220.00	\$0.00	-\$220.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
1/15/18	X-ray	\$180.35	-\$60.35	\$120.00	\$0.00	\$0.00	\$120.00	\$0.00	\$120.00	\$0.00	\$0.00	\$120.00	
1/15/18	Lab	\$350.00	-\$120.00	\$230.00	\$0.00	\$0.00	\$230.00	\$0.00	\$230.00	\$0.00	\$0.00	\$230.00	
1/15/18	Room & board	\$5,000.00	-\$980.00	\$4,020.00	\$0.00	-\$3,370.00	\$650.00	\$0.00	\$650.00	\$0.00	\$0.00	\$650.00	
<b>Subtotal</b>		\$5,930.35	-\$1,340.35	\$4,590.00	\$0.00	-\$3,590.00	\$1,000.00	\$0.00	\$1,000.00	\$0.00	\$0.00	\$1,000.00	
<b>Dr. Jake Giovanni, ABC Hospital Patient Name: John Doe Claim #: 222222222222 (In-Network)</b>													
1/15/18	Lab	\$300.00	\$0.00	\$300.00	\$0.00	\$0.00	\$300.00	\$0.00	\$0.00	\$0.00	\$300.00	\$300.00	A
<b>Subtotal</b>		\$300.00	\$0.00	\$300.00	\$0.00	\$0.00	\$300.00	\$0.00	\$0.00	\$0.00	\$300.00	\$300.00	
<b>Grand total</b>		\$6,230.35	-\$1,340.35	\$4,890.00	\$0.00	-\$3,590.00	\$1,300.00	\$0.00	\$1,000.00	\$0.00	\$300.00	\$1,300.00	

This provider will bill you this amount.



**HAVE QUESTIONS?**

Call the number on your ID card.

Or log in to your account at [bluecrossma.com/myblue](http://bluecrossma.com/myblue).

For TTY, call 711

\* Includes charges from this coverage period only. Log in to your account at [www.bluecrossma.com/myblue](http://www.bluecrossma.com/myblue) for your plan effective date.

- E** Your recent claims, including dates of service, names of providers, the amounts charged, and payment details.
- F** The amount you owe for each service.
- G** How we determined what you owe, including copayments, deductible, and co-insurance.
- H** Additional information on how we processed your claims.
- I** The final amount you'll owe your provider for services after we cover our share of the cost. If you have additional insurance, this doesn't apply to you.
- J** A detailed breakdown of your deductible and out-of-pocket maximum, including the amounts you've previously applied towards these.

View your plan information and recent claims at [bluecrossma.com/myblue](http://bluecrossma.com/myblue).

## Questions?

Call us at the number on your ID card or log in to your account at [bluecrossma.com/myblue](http://bluecrossma.com/myblue), click **Contact Us**, then enter your question using the **secure inquiry form** in the Member Service section.

Left Blank Intentionally



MASSACHUSETTS

# GETTING MORE. NOW THERE'S A PLAN.

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

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



## UNLOCK THE POWER OF YOUR PLAN

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



COVERAGE  
AND BENEFITS



CLAIMS AND  
BALANCES



FITNESS AND WEIGHT-  
LOSS REIMBURSEMENT



MEDICATION  
LOOKUP



VIDEO  
DOCTOR VISITS USING  
WELL CONNECTION

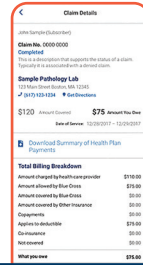
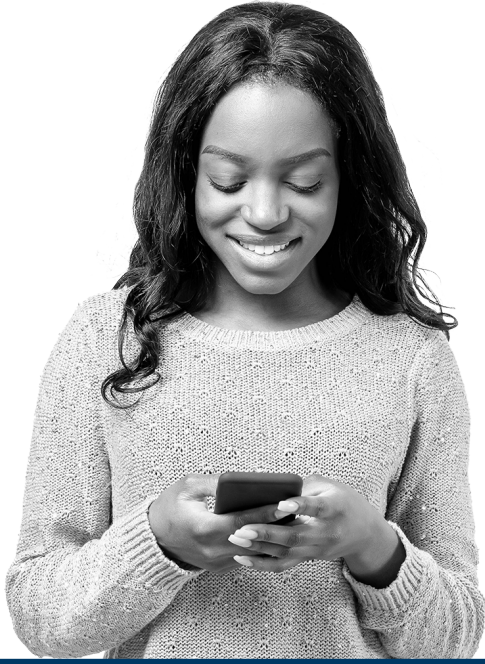
### Get the App

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

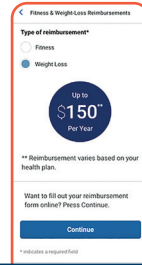
# STAY ON TOP OF YOUR COVERAGE

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

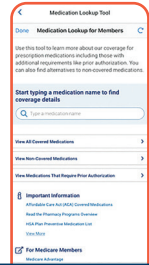
## YOUR PLAN IN YOUR HAND



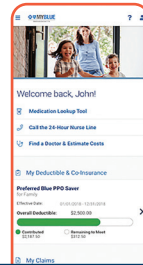
**Track claims and benefits**  
Keep up to date on benefits and coverage.



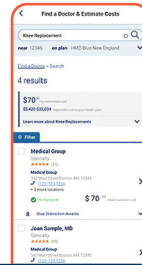
**Fitness and weight-loss reimbursement**  
The online forms are here, along with other savings and offers.



**Your medications at a glance**  
Their names, costs, and prescriptions at your fingertips.



**Check deductible balances**  
End the guesswork and know for sure every time.



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



**Need your cards**  
Access your ID cards without opening your wallet.

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



## GET THE MYBLUE APP

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

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).

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association. ® Registered Marks and TM Trademarks are the property of their respective owners. © 2022 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

99-001093204 (4/22)

Left Blank Intentionally



MASSACHUSETTS

# STOPPING THE FLU STARTS WITH YOU

## Get your no-cost<sup>1</sup> flu shot!

If you haven't gotten your flu shot yet, now's the time. It will help protect you and everyone around you from getting sick, especially young children and older adults who are most at risk. The Centers for Disease Control and Prevention (CDC) says that it's safe,<sup>2</sup> effective, and can be given at the same time as the COVID-19 vaccine.<sup>3</sup> Get your no-cost flu shot at a convenient location near you. We're in this together!



## WHERE TO GET YOUR SHOT



### Flu shot providers

- Your in-network primary care provider (PCP)
- Limited service clinics (such as a MinuteClinic<sup>®</sup> at CVS<sup>®</sup>)
- Urgent care centers
- Community health centers
- Public access clinics (available in some cities and towns and may be available at no charge)
- Hospital outpatient departments
- Skilled nursing facilities (for members in outpatient care, like physical or occupational therapy)
- Home health care providers (in your home, or at a flu clinic hosted by a home health care provider)
- Certified nurse/midwife's office
- Physician assistant's office or specialist's office
- Nurse practitioner's office
- Pharmacies



### Find a flu shot provider near you

- Visit [vaccines.gov](https://www.vaccines.gov) and click **Find Flu Vaccines** at the top of the page.
- To verify the provider is in network, sign in to MyBlue or create an account at [bluecrossma.org](https://www.bluecrossma.org) and click **Find a Doctor & Estimate Costs**.
- If you need additional help, call Team Blue at **1-800-262-2583**.

## Myth:

**“The flu is the same as a bad cold.”**

Learn fact from fiction at [bluecrossma.org/flu](https://www.bluecrossma.org/flu).

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

2. CDC, "Influenza (Flu) Vaccine Safety," August 25, 2022; [cdc.gov/flu/prevent/vaccinesafety.htm](https://www.cdc.gov/flu/prevent/vaccinesafety.htm).

3. CDC, "Getting a Flu Vaccine and a COVID-19 Vaccine at the Same Time," October 25, 2022; [cdc.gov/flu/prevent/coadministration.htm](https://www.cdc.gov/flu/prevent/coadministration.htm).

## YOUR BEST SHOT AT AVOIDING THE FLU

To prevent getting sick, make the following steps part of your routine:



Get your  
flu shot



Avoid close contact  
with people who  
are sick



Wash your hands  
frequently



Avoid touching  
your eyes, nose,  
and mouth



Get plenty of rest,  
exercise, fluids, and  
good nutrition

## TIPS FOR GETTING YOUR SHOT

- Make an appointment ahead of time, if possible, to avoid a wait.
- If the location doesn't take appointments, call and ask when slower times of the day/week are — try to go then.
- Pharmacies inside big-box retail chains and grocery stores, or local independent pharmacies, may be less busy than standalone pharmacies.



## LEARN MORE

Just about everyone six months and older should get the flu shot. If you aren't feeling well or have a health condition, talk to your PCP before getting vaccinated. Learn more about the flu and the flu shot at [bluecrossma.org/flu](https://bluecrossma.org/flu).



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).

Left Blank Intentionally



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.



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).

Left Blank Intentionally



MASSACHUSETTS

# LEARN ABOUT TIERS

## BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FORMULARY

The following information explains our tiered pharmacy plans with the Blue Cross Blue Shield of Massachusetts formulary (list of covered medications), and how those tiers determine the cost of your medications.

Our formulary includes a range of generic and brand-name medications, which are placed into tiers. Your out-of-pocket costs will depend on your plan benefits and the tier of your medication.



# HOW TIERS DETERMINE WHAT YOU PAY FOR MEDICATIONS

Our list of covered medications is based on a tiered cost structure. When you fill a prescription, the amount you pay the pharmacy is determined by your medication's tier and your benefits. The amount you pay may also include your copayment, co-insurance, and deductibles. The pharmacist will tell you what you owe at checkout. To find your out-of-pocket costs in advance, download the MyBlue app, or create an account at [bluecrossma.org](https://bluecrossma.org). Once signed in, click **Price a Medication** under **My Medications**.

# HOW COVERED MEDICATIONS ARE PLACED INTO TIERS

Medications are placed into tiers according to a variety of factors, including what they're used for, their cost, and whether equivalent or alternative medications are available. Lower-tier medications typically cost less than higher-tier medications. For example, in a 3-tier structure, you'll likely pay the least for Tier 1 medications and the most for Tier 3 medications.

Pharmacy plans can use one of the five different tier structures outlined in this document. Check your plan materials to see which tier structure your plan uses, and to learn more about how medications are covered.<sup>1</sup>

## Learn more about your coverage

For more information about your pharmacy benefits, sign in to MyBlue at [bluecrossma.org](https://bluecrossma.org).

<sup>1</sup>. Exceptions may apply. For example, the brands and preferred brands tiers could include some generic medications in addition to brand-name medications.

# OUR TIER STRUCTURES

## 2-TIER

### Tier 1: Generics

Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same Food & Drug Administration (FDA) requirements.

### Tier 2: Brands

Brand-name medications cost more than generic medications, so you'll **pay more** if you use them.

## 3-TIER

### Tier 1: Generics

Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same FDA requirements.

### Tier 2: Preferred brands

These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.

### Tier 3: Non-preferred brands

Non-preferred brand-name medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred brands.

## 4-TIER

### Tier 1: Preferred generics

These medications are preferred because they cost less than other generic medications.

### Tier 2: Non-preferred generics

Non-preferred generic medications cost more than preferred generics, so you'll **pay more** if you use them instead of preferred generics.

### Tier 3: Preferred brands

These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.

### Tier 4: Non-preferred brands

Non-preferred brand-name medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred brands.

## 5-TIER

<b>Tier 1: Generics</b>	Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same FDA requirements.
<b>Tier 2: Preferred brands</b>	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
<b>Tier 3: Non-preferred brands</b>	Non-preferred brand-name medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brands.
<b>Tier 4: Preferred brand specialty</b>	These specialty medications are preferred because they're safe, effective alternatives to more expensive, brand-name specialty medications.
<b>Tier 5: Non-preferred brand specialty</b>	Non-preferred brand-name specialty medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brand-name specialty medications.

## 6-TIER

<b>Tier 1: Preferred generics</b>	These medications are preferred because they cost less than other generic medications.
<b>Tier 2: Non-preferred generics</b>	Non-preferred generic medications cost more than preferred generics, so you'll <b>pay more</b> if you use them instead of preferred generics.
<b>Tier 3: Preferred brands</b>	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
<b>Tier 4: Non-preferred brands</b>	Non-preferred brand-name medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brands.
<b>Tier 5: Preferred brand specialty</b>	These specialty medications are preferred because they're safe, effective alternatives to more expensive, brand-name specialty medications.
<b>Tier 6: Non-preferred brand specialty</b>	Non-preferred brand-name specialty medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brand-name specialty medications.



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**.





\* Registered Marks of the Blue Cross and Blue Shield Association. © 2023 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.  
002350867

55-001542472 (9/23)

Left Blank Intentionally



MASSACHUSETTS

# SAVE TIME AND MONEY WITH MAINTENANCE CHOICE VOLUNTARY

Maintenance Choice Voluntary saves you 33% on the cost of your maintenance medications,<sup>1</sup> also known as long-term medications, when you switch to a 90-day supply and fill your prescriptions at a CVS Pharmacy<sup>®</sup> retail location, or through the mail service pharmacy.



## SWITCHING BRINGS BENEFITS



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



Convenience of filling medications at any of the 9,000+ CVS retail pharmacies.



No additional cost for standard delivery through the mail service pharmacy.



Fewer trips to the pharmacy, or none at all.

## EXAMPLE OF HOW YOU CAN SAVE<sup>2</sup>

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

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

(continued)

## HOW TO SWITCH TO 90-DAY FILLS



### CVS Retail Pharmacy

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

To make sure you receive emails, use MyBlue to update your communication preferences:

- 1 Download the MyBlue app, or create an account at [bluecrossma.org](https://bluecrossma.org).
- 2 Once signed in, click **Pharmacy Benefit Manager** under **My Medications**.
- 3 Go to **Profile**.
- 4 Select **Communication preferences** under **Update My Profile**.



### Mail Service Pharmacy

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



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).

Left Blank Intentionally



MASSACHUSETTS

# 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.<sup>1</sup>



## 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 SAVE<sup>2</sup>

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.

(continued)

## HOW TO USE THE MAIL SERVICE PHARMACY

Download the MyBlue app or create an account at [bluecrossma.org](https://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**).



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**).

CaremarkPCS Health, LLC ("CVS Caremark") is an independent company that has been contracted to administer pharmacy benefits and provide certain pharmacy services for Blue Cross Blue Shield of Massachusetts. CVS Caremark is part of the CVS Health family of companies. Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association. \* Registered Marks of the Blue Cross and Blue Shield Association. © 2022 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



# 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](http://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.

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

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.



Please fold here →

Please fold here →

\* WEB \*

Please fold here →

Please fold here →

\* 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

**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)



Please fold here →

Please fold here →

Please fold here →

Please fold here →

\* WEB \*

\* WEB \*

Left Blank Intentionally



MASSACHUSETTS

# DOCTORS ON CALL, ON YOUR DEVICE.

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



## REAL DOCTORS. REAL EXPERIENCE. REALLY FAST.



**GET MEDICAL CARE  
24/7**

Speak face to face with a doctor, in the privacy of your home.<sup>1</sup>



**THERAPY THAT  
COMES TO YOU**

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



**HIGHLY EXPERIENCED,  
HIGHLY RATED**

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

### Sign In

Download the MyBlue App from the App Store<sup>®</sup> or Google Play<sup>™</sup>, or go to [bluecrossma.org](https://bluecrossma.org).

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

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



## IS A VIDEO DOCTOR VISIT RIGHT FOR ME?

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

### "I'm not feeling well."

Get care for:

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

### "I need emotional support."

Talk to a therapist about:

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

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

### "My loved one is under the weather."

If they're on your plan:

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



## WELL CONNECTION IS HIGHLY RATED: 4.8 out of 5 Doctor and Provider rating from our members<sup>3</sup>

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

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

4. Prescription availability is defined by doctor judgment.

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).

Left Blank Intentionally

# Hinge Health for Chronic Back and Joint Pain

## What Is Hinge Health?

Hinge Health, an independent company, provides a preventive pain management program that helps adults proactively manage chronic back and knee pain through a 12-week, coach-led, digital experience. The program was developed using proven, non-surgical care guidelines, and includes detailed walk-throughs of exercise therapy, educational articles, and behavioral health interventions.

## How Does It Work?

Hinge Health is an easy-to-use, high-impact program that gives members the tools to manage chronic pain effectively, without leaving their home or relying on medications and surgery. With this program, they'll gain access to:

### Supporting Technology

Getting started with Hinge Health is simple—employees take a quick online clinical screening, and then receive the program kit by mail. Each kit will include Bluetooth®-enabled exercise bands with motion-sensing technology, and a tablet pre-loaded with the Hinge Health app, all ready to use right out of the box.

### Weekly Personalized Educational Resources

Your employees receive new articles that explain their specific condition, discuss potential treatment possibilities with an emphasis on non-surgical options, and dispel common misconceptions.

### Guided Exercise Therapy

Participants will receive a tailored program of simple stretching and strengthening exercises. As participants perform the exercises, a health coach monitors them to ensure safe form and movement, and offers real-time feedback and support.

## The Cost of Musculoskeletal (MSK) Complications

1 out of 6 health care dollars is spent on MSK<sup>1</sup>

50% of your workforce suffers from MSK pain<sup>2</sup>

77% of MSK's costs are for surgeries and opioid medications<sup>3</sup>

## Impact of Hinge Health

Hinge Health participants:

- experience 70% less pain
- avoid two out of three MSK-related surgeries
- avoid the need for opioid-based pain medications

## Everything They Need in One Kit

Hinge Health participants receive:

- Bluetooth-enabled exercise bands
- A pre-loaded Hinge Health tablet and app
- An assigned health coach
- Co-branded marketing materials
- Educational webinars

## Three Steps to Behavioral Health Interventions

1. Each participant is screened for a variety of psychosocial risks to identify mental barriers to pain management. Each risk is targeted with cognitive-behavior therapy exercises, to set participants up for success.
2. All program communications can be customized to their preference—they can choose to receive information through text, email, phone, or in-app.
3. An assigned health coach keeps participants on track toward their pain management goal, providing support from start to finish.

## Ease of Implementation

Getting started with Hinge Health is simple—all your employees need to do when they're ready to get started is:

1. Register online through the Hinge Health portal, set up specifically for your employees
2. Take their online clinical screening
3. Participate in a program kick-off phone call with their assigned health coach
4. Engage in the 12-week program

## The Blue Cross and Hinge Health Partnership Gives You:

- Simple use-based pricing
- Fewer claim outcomes involving pain, surgery, and depression, backed by two randomized, controlled trials
- Proven implementation with major self-insured employers
- A turnkey deployment playbook led by Hinge Health's Client Success team

## Eligibility Requirements

Adult members (30+ years) actively enrolled within the Blue Cross Blue Shield of Massachusetts medical account (Active and COBRA) are eligible for Hinge Health with the exception of Medex, Medicare Advantage, or any account-specific group exclusions

## Hinge Health Engages People



- 30+ exercise therapy sessions completed in just 12 weeks
- 3+ weekly health coach interactions
- 70+ pages of patient education read over program duration

Data represented is based on vendor calculations and actual results may vary.

## People Love This Program



- 9.2/10 participant satisfaction score
- 70 Net Promoter Score®

## Questions?

If you have questions or concerns about Hinge Health, contact your Blue Cross account executive.

1. Source: Huse DM, Marder WD, "What Are the Leading Drivers of Employer Healthcare Spending Growth?" Truven Health Analytics, April 2013.  
2. Source: The United States Bone and Joint Initiative, "The Burden of Musculoskeletal Diseases in the United States," 2016: "On an age-adjusted basis, musculoskeletal conditions are reported by 54 persons per every 100 in the population."  
3. Based on Hinge Health book of business.

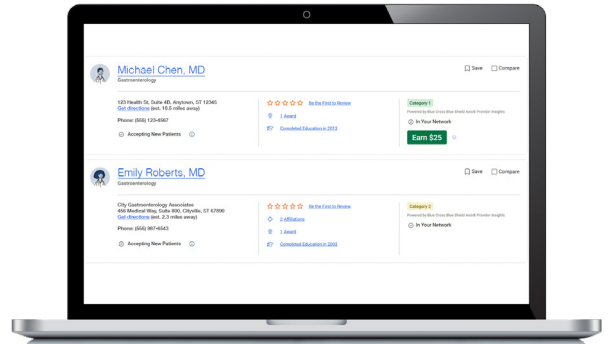
Left Blank Intentionally



MASSACHUSETTS

# GET UP TO \$400 IN REWARDS FOR THE CARE YOU NEED

Taking care of your health is important. So is managing costs. With SmartShopper<sup>®1</sup>, you can easily find providers and facilities that deliver high-quality care at more affordable prices — and get rewarded when you visit them for qualifying care. Plus, it's included in your plan at no additional cost.



## EARNING REWARDS IS EASY

Earn rewards for choosing high-value providers and facilities for qualifying care, from office visits to procedures and tests, including MRIs, colonoscopies, hip and knee replacements, and more. Use the SmartShopper search tool within MyBlue, your online member account, to find and compare rewards-eligible care.

### 1. Shop for care

Search by the type of qualified care you need to find high-value providers and facilities and compare rewards.

### 2. Get your care

Schedule an appointment with a rewards-eligible provider or facility.

### 3. Get rewarded

After you get your care, you'll receive a monetary reward within eight weeks<sup>2</sup>.

## Get started

Sign in to MyBlue or create an account at [bluecrossma.org](http://bluecrossma.org), go to [My Care](#), then click [Start Saving with SmartShopper](#).

1. SmartShopper is administered by the independent company Zelis<sup>®</sup>.

2. A member will typically receive their reward within six to eight weeks of the claim processing. If more than eight weeks pass and you haven't received your reward, call Zelis Care Concierge at 1-877-281-3722, Monday through Thursday, 8:00 a.m. to 8:00 p.m. ET, or Friday, 8:00 a.m. to 6:00 p.m. ET.



## EXTRA SUPPORT FROM THE SMARTSHOPPER CARE CONCIERGE TEAM

SmartShopper's team of experts is here to help you find rewards-eligible services, schedule appointments, coordinate your care, and more. Call them at **1-877-281-3722**, Monday through Thursday from 8:00 a.m. to 8:00 p.m. ET and Fridays from 8:00 a.m. to 6:00 p.m. ET.

Left Blank Intentionally

# HOW DEPENDENT CHILDREN CAN RECEIVE COVERAGE WHEN LIVING OUTSIDE OF NEW ENGLAND

Coverage is available for dependents living outside of the New England service area under the Network Blue New England Plan & the Access Blue N.E. plan. In addition to emergency and urgent care, covered dependents\* on the plans living outside the New England service area can receive in-network coverage for non-emergency medical and mental health care when they register with Blue Cross Blue Shield of Massachusetts.

## HERE IS WHAT YOU NEED TO KNOW:

### Registration is required to receive in-network care outside the New England service area:

Dependents who live outside of the service area must register by calling Blue Cross Blue Shield of Massachusetts Member Service at 1-800-782-3675. The plan subscriber must contact Blue Cross Member Service for dependents under the age of 26.

### What services are covered when I register?

Services that aren't usually covered when delivered outside the New England service area, such as:

- Preventive care services
- Outpatient medical care office visits
- Mental health care
- Follow-up care, when required, after leaving the emergency room or after an inpatient hospital stay.

**Please note:** Some services may require authorization from your provider. Call Blue Cross Member Service for assistance.

### Do I need to see a Blue Cross Blue Shield provider when seeking care outside of New England?

Yes, you must see a Blue Cross Blue Shield participating doctor when receiving eligible care outside of New England. To find a participating doctor, visit [bcbs.com/find-a-doctor](https://bcbs.com/find-a-doctor). To search, use the prefix located on the front of your ID card or call Member Service.

\*Subscribers and spouses are not included as covered dependents.

#### URGENT AND EMERGENCY CARE ARE ALWAYS COVERED

Dependents are covered if they get sick or injured and need immediate medical care at an emergency room or urgent care center. For urgent care, please call Blue Cross Member Service within 48 hours for authorization.

## Questions?

Call Blue Cross Member Service at 1-800-782-3675.

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).

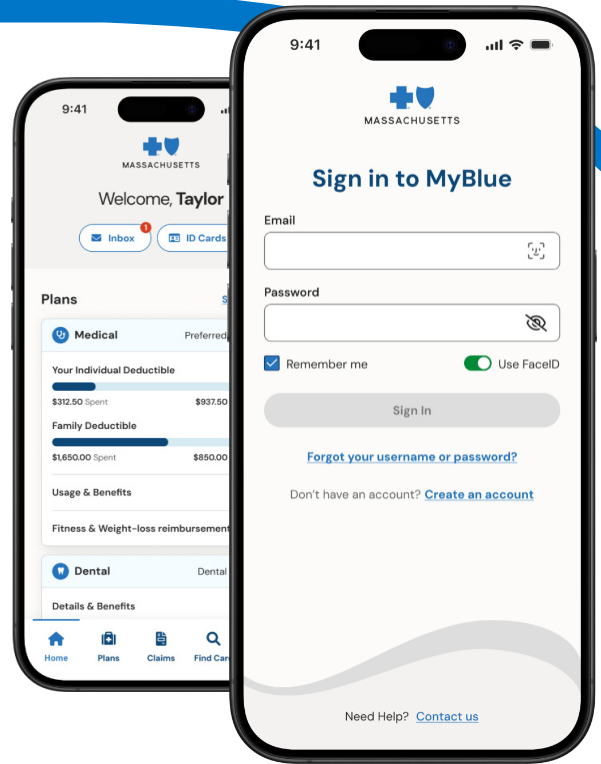
Left Blank Intentionally



MASSACHUSETTS

# EASILY ACCESS YOUR HEALTH PLAN WITH MYBLUE

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



## DISCOVER THE POWER OF MYBLUE

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



COVERAGE AND  
BENEFITS INFORMATION



YOUR CLAIMS  
AND BALANCES



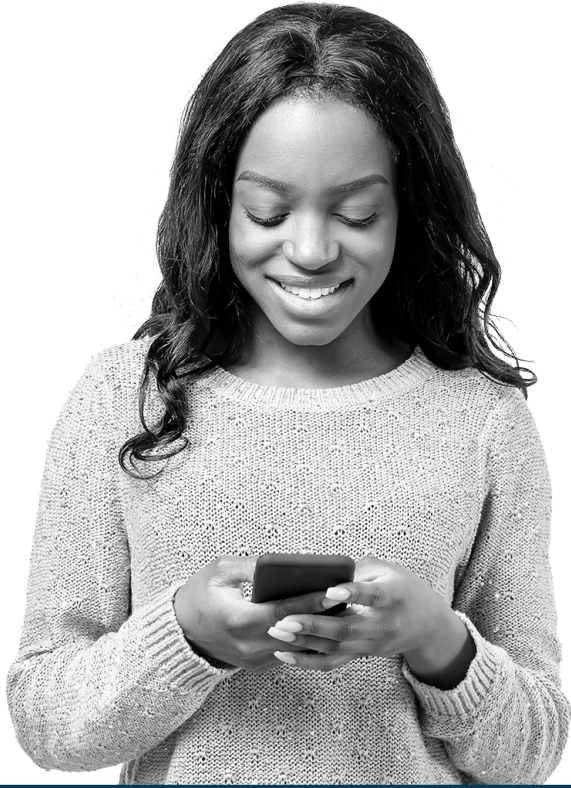
VIDEO DOCTOR VISITS  
USING WELL CONNECTION

## Get started

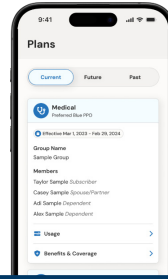
Create an account at [bluecrossma.org](https://bluecrossma.org) or download the app from the App Store<sup>®</sup> or Google Play<sup>™</sup>. If you have questions, call Member Service at **1-800-832-3871**.

# YOUR HEALTH PLAN IN YOUR POCKET

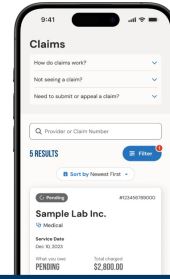
The MyBlue app makes it easy to:



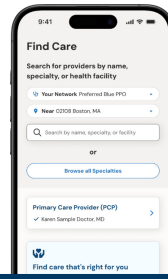
Download the MyBlue app and see your covered benefits and services by clicking on Benefits & Coverage under Plans.



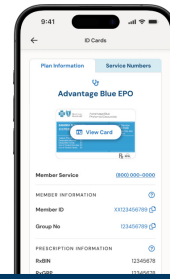
Find, understand, and use your benefits



Review your claim details with guidance on next steps



Get personalized care options that fit your unique needs



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



## GET THE MYBLUE APP

You can download the MyBlue app from the App Store<sup>®</sup> or Google Play<sup>™</sup>.



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).

Left Blank Intentionally



MASSACHUSETTS

## CALL TEAM BLUE

Let us know if you have more than one plan by calling us at **1-888-799-1888**.

# COORDINATION OF BENEFITS ENSURES YOUR BEST COVERAGE

If you're covered by more than one medical or dental insurance plan, you must inform us which ones you have so we can coordinate your benefits. This will help us work with your other plans, to make sure you get the best coverage when you receive medical or dental services. It will also ensure that your claims are processed correctly.

## HOW TO KNOW WHEN COORDINATION OF BENEFITS IS NEEDED

When you have more than one insurance plan, one plan is designated as your primary plan and will pay your claims first. The other plan(s) will pay toward the remaining cost. Federal and state rules will usually determine which plan is primary. You may need coordination of benefits if:

- You and your spouse each have separate insurance plans through your employers
- Your child has one insurance plan through school and another through you or an employer
- Your child has multiple plans as the result of a divorce or custody arrangement
- You or a family member also have Medicare coverage

## WHAT TO DO IF YOU HAVE MORE THAN ONE MEDICAL OR DENTAL PLAN

- Call each insurer to let them know. Each insurer can tell you which plan is primary and which is secondary. When calling, be sure you have your member ID cards ready.
- When you visit a doctor, dentist, or hospital, present each insurance card to the office on the day of your visit. This information is needed to determine which company should be billed as a primary insurer, and which should be billed as a secondary insurer.
- If one of your insurance plans is canceled, you'll need to inform the other plan(s).

## IF YOU'RE TURNING 65 YEARS OLD AND THINKING ABOUT MEDICARE

Call Medicare directly at **1-800-MEDICARE (1-800-633-4227)**.

If you sign up for Medicare, call us at **1-888-799-1888** to submit your new plan information. If you don't call us, your claims could be delayed or processed incorrectly.

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).

Left Blank Intentionally



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](mailto: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](https://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](https://hhs.gov)**.

Left Blank Intentionally

# 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'doowólgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíjijí' béésh bee hodíílnih (TTY: 711).