Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group # Transfering To:
City of Waltham		002330957 - Active/U65

Current BCBS ID #, If any	Requested Effective Date (MM DD YYYY)	Date of Hire (MM DD YYYY)	Current Dental Group #:	Dental Group # Transferring To
			N/A	N/A

Type of Transaction

❒ ADD ❒ CANCEL
❒ CHANGE Three digit termination code ☐☐☐
❒ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

❒ Open Enrollment
❒ New Hire
❒ COBRA

Change to Family
❒ Add Spouse
❒ Add Dependent

❒ Loss of Coverage (HIPAA Continuation of Coverage Letter required)
❒ Other: _____

2. Yourself (Member 1)

What products?
❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England
❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue
❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group)
❒ Network Blue ☑ PPO ❒ Saver Blue

Membership Type (Medical) ❒ Individual ❒ Family
Membership Type (Dental) N/A ❒ Individual ❒ Family

First Name	M.I.	Last Name	Sex	Date of Birth

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Home Phone ( )	Cell Phone ( )	Email

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ☑	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered)

Plan Type: ☑ Medical ❒ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ☑	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

4. Your Eligible Dependents (Member 3, 4 and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ☑ Medical ❒ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ☑ Medical ❒ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ☑ Medical ❒ Dental

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **HSA: Health Savings Account**			
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

MASSACHUSETTS

Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

Before You Begin

Please carefully read the instructions below.

For members of HMO Blue,® Network Blue,® Blue Choice,® HMO Blue New England,℠ or Blue Choice New England℠: You're required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting **bluecrossma.com** and selecting **Find a Doctor**.

For Access Blue℠ Members: Although you're not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

Important: Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Please be sure to check either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Sections 2 and 3.

Please print two copies of your completed application. Keep one for your records and give the other to your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you're seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298
Fax: 1-617-246-7531

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Instructions

Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

Type of Transaction—Check the box(es) that apply.

Subscriber Cancellation Codes. If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling
041	• Changing to other health plan • Voluntary termination • COBRA cancellation (under 18 months or nonpayment)
042	• Over 65, changing to Group Medex® plan. (Requires Medicare A and B) • Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) • Over 65, changing to Medicare supplement other than Medex plans.
043	• Medicare (age =< 65)

Code #	Reason for Canceling
061	• Left employment • COBRA ending
063	• Transfer
064	• Cancellation as of original effective date
070	• Deceased
071	• Moved out of state (out of HMO service area)
076	• Military service

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions, contact your account service representative.
- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation. If you have questions, contact your account service representative.

Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID#—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (***not*** the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at **1-800-821-1388**. A representative will be happy to help you select a doctor. PCP ID number can be found at **bluecrossma.com**, select **Find a Doctor**.

Other Insurance—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*)) in the correct box. If you have other insurance, please write the name of the other insurance company and your member identification number.

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Member 2

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an **Individual** membership.)

Other Insurance—Does your spouse have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a **Family** membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: dependents cannot be covered under an **Individual** membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

For each option:

Start Date: Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated, and submitted the completed application for these accounts on or before that date.

End Date: Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions, please see your employer.

Note: If you are transferring from one medical/dental plan to another plan, please complete Section 5 of the Enrollment and Change Form to let us know that you will be continuing your personal savings account..

Section 6 Signatures (Employer & Employee)

Employee: Please sign and date the application and return it to your employer. Employer: Please sign and date the application and return to Blue Cross Blue Shieldof Massachusetts.

Please mail to:

P.O. Box 986001
Boston, MA 02298
or fax to 1-617-246-7531

* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

Left Blank Intentionally

BlueCross® BlueShield®

SUMMARY OF BENEFITS

BLUE CARE ELECT PREFERRED

$15 OFFICE VISIT COPAYMENT

City of Waltham

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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

The Plan Sponsor believes that this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Act). As permitted by the Act, a grandfathered plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being grandfathered means the plan may not include certain consumer protections of the Act that apply to other plans, such as providing preventive health services without any cost sharing. However, a grandfathered plan must comply with certain other consumer protections of the Act, such as the elimination of annual and lifetime limits on most benefits.

Questions about which protections do or do not apply, and what causes a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at **1-781-314-3268**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a summary of the protections which do and do not apply to grandfathered health plans.

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

YOUR CHOICE

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

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

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

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

- Visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**

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

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

Your out-of-pocket maximum is the most that you could pay during a calendar year for out-of-network coinsurance for covered services. Your out-of-pocket maximum is **$1,000** per member (or **$2,000** 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).

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

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

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

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • One visit per calendar year for age 2 to 11 • One visit every two calendar years for age 12 to 18	$15 per visit (no cost for related routine lab tests and X-rays)	20% coinsurance after deductible
Routine adult physical exams, including related tests, according to age-based schedule as follows: • One exam every five calendar years from age 19 through age 29 • One exam every three calendar years from age 30 through age 39 • One exam every two calendar years from age 40 through age 54 • One exam per calendar year for a member age 55 or older	$15 per visit (no cost for related routine lab tests and X-rays)	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	$15 per visit (no cost for related routine lab tests)	20% coinsurance after deductible
Routine hearing exams, including routine tests	$15 per visit (no cost for routine tests)	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 every 24 months)	$15 per visit	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$50 per visit (waived if admitted or for observation stay)	$50 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits	$15 per visit	20% coinsurance after deductible
Mental health or substance use treatment	$15 per visit	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the in-network designated telehealth vendor	 Same as in-person visit $15 per visit	 Same as in-person visit Only applicable in-network
Chiropractors' office visits	$15 per visit	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	$15 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$15 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$15 per visit	20% coinsurance after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	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	Nothing	20% coinsurance after deductible
Prosthetic devices	Nothing	20% coinsurance after deductible
Surgery and related anesthesia • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit	 $15 per visit** Nothing	 20% coinsurance after deductible 20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Rehabilitation hospital care (up to 100 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.
** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

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

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

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	$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 1-800-782-3675, or visit us online at bluecrossma.org.

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

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

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

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

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

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

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

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

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

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

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PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

Arabic/ةيبر:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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55-1493 (6/22)

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://www.city.waltham.ma.us/human-resources-department/pages/insurance-0**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **bluecrossma.org/sbcglossary** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 in-network; $250 member / $500 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency room and emergency transportation.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$0 in-network; $1,000 member / $2,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Specialist visit	$15 / visit; $15 / chiropractor visit; $15 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	$15 / visit; No charge for related routine lab tests and x-rays	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail or mail service supply	Not covered	
	Non-preferred brand drugs	$45 / retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$50 / visit	$50 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / 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 need mental health, behavioral health, or substance abuse services	Outpatient services	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first for out-of-network; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	

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	Home health care	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Rehabilitation services	$15 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first for out-of-network; limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 100 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	20% coinsurance	Deductible applies first for out-of-network
	Hospice services	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-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 your child needs dental or eye care	Children's eye exam	$15 / visit	20% coinsurance	Deductible 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% coinsurance for members with a cleft palate / cleft lip condition	Deductible 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 and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

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

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

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

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

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

About these Coverage Examples:

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

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

■ The plan's overall deductible	$0
■ Delivery fee copay	$0
■ Facility fee copay	$0
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$15
■ Primary care visit	$15
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$15
■ 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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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

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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.[1]

BENEFITS OF USING THE MAIL SERVICE PHARMACY

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

There's no additional cost for standard delivery.

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

EXAMPLE OF HOW YOU'LL SAVE[2]

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**. 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

RESET FORM PRINT FORM

CVS caremark®
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

Please fold here →

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

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

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

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

Last Name | First Name | MI | Suffix (JR, SR)

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

City | State | ZIP Code

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

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

1) 2) 3) 4)

5) 6) 7) 8)

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

* 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 | First Name | MI | Suffix (JR,SR)

Nickname | 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 | First Name | MI | Suffix (JR,SR)

Nickname | 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 MMYY

Credit card holder signature/Date

◯ **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.

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)**

◯ **Next business day ($23)**

Faster delivery can only be sent to a street address, not a PO Box

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 → * WEB *

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MASSACHUSETTS

GET TO KNOW THE MEDICATION LOOKUP TOOL

With a simple search, you can see which medications your plan covers.

Our **Medication Lookup** tool lets you easily learn more about your coverage for prescription medications, including those with additional requirements like Prior Authorization. Search anytime, anywhere at **bluecrossma.org** or using the MyBlue app.

KEY FEATURES

Using the tool, you can:

SEARCH FOR ANY MEDICATION

See if it's covered by your plan

GET DETAILED INFORMATION

Including the medication's strength, tier, and how it's dispensed

VIEW ADDITIONAL COVERAGE REQUIREMENTS

Such as Prior Authorization, Step Therapy, and Quality Care Dosing

SEE COVERED ALTERNATIVES

For non-covered medications

Start Searching

For more information about your prescription coverage, sign in to MyBlue at **bluecrossma.org** or open the MyBlue app, and go to **Medication Lookup Tool** under **My Medications**. If you're not a member, you can get more information by visiting **bluecrossma.org/medication**.

GETTING COVERAGE INFORMATION, SIMPLIFIED

We're making it easier than ever for everyone to learn more about our medication coverage.

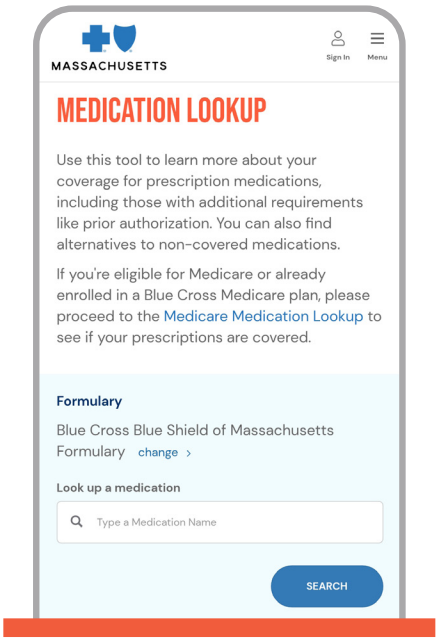
PERSONALIZED SEARCH

When you're signed in to your MyBlue account, your plan's formulary and tier structure will be automatically displayed in the tool. That way, you'll know you're getting the most accurate search results for your plan.

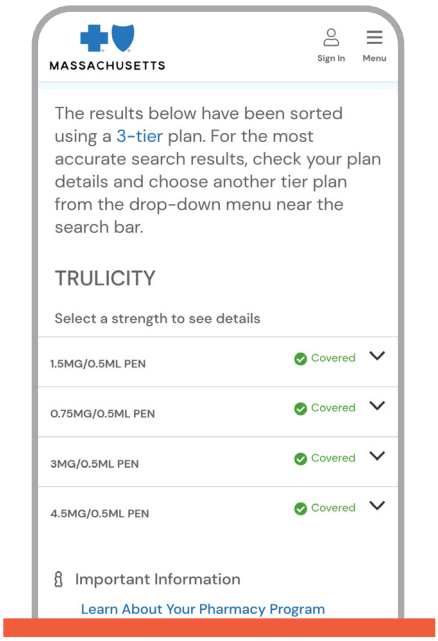
ANYONE CAN USE IT

The **Medication Lookup** tool is available to everyone, even if you aren't a member yet. You can easily find out if your medication is covered, or see covered alternatives, before you enroll.

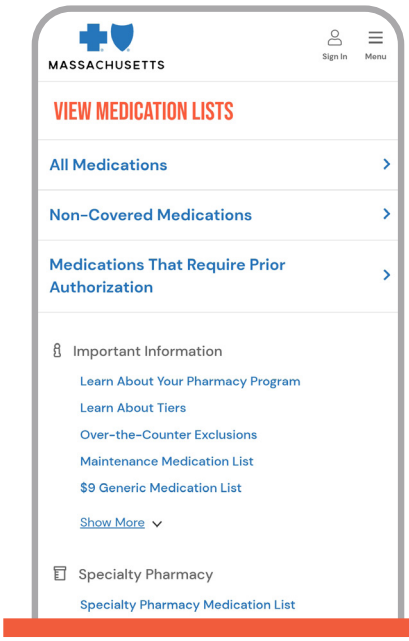
HOW TO USE THE TOOL



Sign in to MyBlue and go to the **Medication Lookup Tool** under **My Medications**. If you're not a member, go to **bluecrossma.org/medication** and choose the formulary you want to search. When not signed in, the tool will default to a 3-tier plan.



Select a medication to see if it's covered and get even more information, including strength and additional coverage requirements. Plus, if it's not covered, you can see covered alternatives.



Access important resources, like medication lists and Specialty Pharmacy Contact Information lists, in the **Important Information** and **Specialty Pharmacy** sections. If you're signed in to MyBlue, this list will be customized to match your benefits.

Learn More

To learn more about your pharmacy benefits, including which tier structure your plan uses, sign in to your MyBlue account at **bluecrossma.org** or check your plan materials for details.

000761253 55-1868 (10/21)

MASSACHUSETTS

EVERYTHING YOU NEED TO LIVE A HEALTHIER LIFE

ahealthyme®
Everything to live a healthier life

If you want to know more about your health and how to make it better, ahealthyme® is a great place to start. With just a few clicks, we'll show you just what you need to live a healthier life. From a health assessment to wellness workshops and interactive tools, ahealthyme is your personal online resource.

WITH AHEALTHYME, MANAGING YOUR HEALTH CAN BE AS EASY AS 1, 2, 3:

1 Start with your health assessment

Taking your health assessment is easy and rewarding. Simply answer questions about eight areas of your health. When done, we'll give you a detailed look at your health today and recommend tools and programs that will help improve it, based on your answers.

2 Take a wellness workshop

Our self-paced wellness workshops are a fun way to be smart about your health. You'll gain insight on health topics that relate to you and get closer to your wellness goal.

Learn about:

- Healthy eating
- Quitting smoking
- Stress management
- Physical fitness
- Much more

3 Stay motivated and stick to your goals

Maintaining good eating and exercise habits can help keep you on track. With ahealthyme, you can record and track your activities on any computer or smartphone and see how you're doing in real time.

Get Started Now

Go to **ahealthyme.com/login** and sign up to begin your journey to healthier living.

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**).

000415852 55-0895 (4/20)

MASSACHUSETTS

MyBlue® Member App

Meet the MyBlue Member App

Simple, Secure, Convenient

Get Health Care Information Quickly and Easily

The MyBlue Member App gives members instant access to their personal health care information anytime they need it. A simple tap connects them to their doctor, recent prescriptions, and claims history.

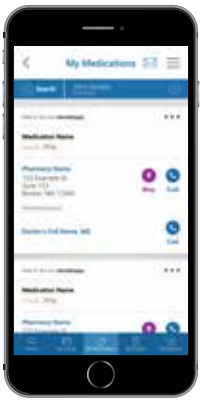
Personalized health care, right at their fingertips:

Use the digital ID card to direct-dial important numbers, email a PDF version to a doctor, or save a digital card to their phone.

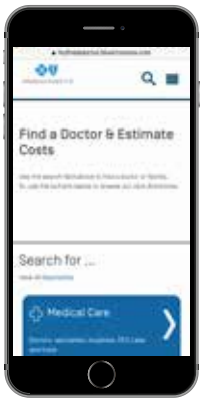
Get access to recent claims history and see copayment amounts.

View financial account balances, like HealthEquity®´ or Blue Cross

Additional MyBlue Member App features:



See prescription history, including dosage and who prescribed it.



Look up and get directions to nearby doctors, dentists, and hospitals.

Receive push notifications and view important information in the Message Center.

Available On

Download on the App Store

GET IT ON Google Play

The MyBlue Member App is not available for members with Federal Employee Program (FEP), Blue Benefit Administrators (BBA), Ancillary (Indigo®'), Medicare Advantage or standalone Part D plans. Those with standalone dental, vision, or wellness coverage cannot register for the app at this time.

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

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

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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**).

MASSACHUSETTS

198499M 55-1776 (06/19)

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).

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ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

001188315 32-6765 (11/21)

MASSACHUSETTS

WEIGHT-LOSS REIMBURSEMENT

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

Qualified for Weight-Loss Reimbursement

Participation fees for:

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

Not Qualified for Weight-Loss Reimbursement

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

GET REIMBURSED IN THREE EASY STEPS

1

Choose
Start by picking a qualified weight-loss program.

2

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

3

Mail
Send the completed form to the address listed.

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

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

Questions?

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

WEIGHT-LOSS REIMBURSEMENT REQUEST

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

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

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial

Address - Number and Street	City	State	Zip Code

Employer's Name

Claim Information

Member Last Name	First Name	Middle Initial	Gender (color in the entire box) ❑ Male ❑ Female	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 of Qualified Weight-Loss Program

Total dollars requested: $ _____

Monthly program participation fee: $ _____

Calendar Year: ___/___/____

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

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

Subscriber's or Member's Signature: **Date: ___/___/____**

Important Information:

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

000414912 55-0774 (5/20)

MASSACHUSETTS

WELLNESS WORKSHOPS

Looking for Support to Reach Your Wellness Goals?

ahealthyme
Everything to live a healthier life

Our interactive, self-paced wellness workshops are designed to help you understand and make healthy choices. These workshops are easy to use and they're available on our secure ahealthyme website. We hope you'll take advantage of them!

HOW DO I SIGN UP FOR A WELLNESS WORKSHOP?

1. Sign in to **ahealthyme.com/login**, then go to **Wellness Workshops** in the top navigation bar and select **Sign Up for a Workshop** from the drop-down list.
2. Select the wellness workshop title you'd like to enroll in under **Add**, and then click **Sign Up.***
3. To begin, click the workshop title when it appears active.

*If **Sign Up** is grayed out, that means you're active in another workshop, and you should click **Add to Queue**. The queued workshop will become active after you complete the active workshop.

Get Started Now

Go to **ahealthyme.com/login** and sign up to follow the path to healthier living.

WHAT YOU'LL LEARN

Our wellness workshops encourage, inspire, and teach you how to better manage your health. Topics include:

- Breathe Easy—Tobacco Cessation Wellness Workshop
- Fight the Flu—Wellness Workshop
- Finding the Right Balance—Weight Management Wellness Workshop
- Fit for Life—Physical Activity Wellness Workshop
- Smart Choices—Healthy Eating Wellness Workshop
- Take a Break—Stress Management Wellness Workshop
- Mindful Living—Mind and Body Connection Workshop
- Rest and Recharge—Sleep Wellness Workshop
- Smart Spending and Saving—Financial Wellness Workshop
- Healthy Mouth, Happy Smile—Dental Wellness Workshop
- Prediabetes Prevention—Wellness Workshop
- Advance Care Planning—Wellness Workshop

HOW IT WORKS

Every week, you'll be assigned articles, videos, trackers, and other tools to help you create and follow a plan to get healthier. You can complete all the tasks at once, or over the course of several days—whichever works best with your schedule. Reminder emails will help to keep you on track toward meeting your goals.

TRACKING PROGRESS

You can view your workshop To-Do list on the home page of the secure ahealthyme website (**ahealthyme.com/login**). Once a task you complete a task, it appears under **Completed** at the bottom of your To-Do list.

TAKE A STEP TOWARD BETTER HEALTH

Sign up for a wellness workshop!

000456712 55-1229 (5/20)

MASSACHUSETTS

DOCTORS ON CALL, ON YOUR DEVICE.

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

REAL DOCTORS. REAL EXPERIENCE. REALLY FAST.

GET MEDICAL CARE 24/7

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

THERAPY THAT COMES TO YOU

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

HIGHLY EXPERIENCED, HIGHLY RATED

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

Sign In

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

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

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

IS A VIDEO DOCTOR VISIT RIGHT FOR ME?

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

"I'm not feeling well."

Get care for:

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

"I need emotional support."

Talk to a therapist about:

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

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

"My loved one is under the weather."

If they're on your plan:

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

WELL CONNECTION IS HIGHLY RATED:

4.8 out of 5 Doctor and Provider rating from our members[3]

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

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

4. Prescription availability is defined by doctor judgment.

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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**).

000770131 55-1287 (5/21)

MASSACHUSETTS

FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

$150

Qualified for Reimbursement:

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

Not Qualified for Reimbursement:

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

Get Started

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

Your reimbursement is waiting!

MASSACHUSETTS

FITNESS REIMBURSEMENT REQUEST

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

Subscriber Information (Policyholder)

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

Claim Information

Member's Last Name	**First Name**	**Middle Initial**	**Date of Birth** ___/___/____

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

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

Name, Address, and Phone Number of Qualified Fitness Expense

Total Dollars requested for Qualified Fitness Expense: $ _____

Calendar year that fees were paid: _____

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

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

Subscriber's or Member's Signature: **Date:** ___/___/____

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

000891752 (2/22)

MASSACHUSETTS

STOPPING THE FLU STARTS WITH YOU

Get your no-cost[1] 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,[2] effective, and can be given at the same time as the Covid-19 shot or booster. Get your no-cost[1] 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
- Limited Service Clinics (such as a MinuteClinic®˝ at CVS®˝)
- 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 Physician's Office
- Nurse Practitioner's Office
- Pharmacies

FIND A FLU SHOT PROVIDER NEAR YOU

- Visit **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** and click **Find a Doctor & Estimate Costs**.
- If you need additional help, call Team Blue at **1-800-262-2583**.

Myth:

"I don't need the flu shot if I'm vaccinated for COVID-19."

Learn fact from fiction at **bluecrossma.org/flu**.

1. Flu vaccines recommended by the Centers for Disease Control and Prevention (CDC) are covered in full when administered by an in-network provider. Exceptions may apply. Check plan materials for details.
2. Centers for Disease Control and Prevention, "Influenza (Flu) Vaccine Safety," August 25, 2022; cdc.gov/flu/prevent/vaccinesafety.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 for flu shots.

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 doctor before getting vaccinated. Learn more about the flu and the flu shot at **bluecrossma.org/flu**.

MASSACHUSETTS

001746729 55-000626727 (11/22)

MASSACHUSETTS

MATERNITY CARE

Supporting you through pre-conception, pregnancy, childbirth, and caring for your new baby

Have questions about getting pregnant, pregnancy, labor, and what to expect during baby's first year? We're here to help you with a full range of maternity programs and benefits. We encourage you to explore all your benefits for starting and growing your family.

Ovia Pregnancy App

We're partnering with Ovia Health™—developer of the Ovia Pregnancy app—to give our members tools to support conception and healthy pregnancies. Go to **oviahealth.com** to download.

Living Healthy Babies®

Our **Living Healthy Babies** website is there when you need it, providing answers, educational resources, and interactive tools—including guidelines for recommended doctor visits. From preparing for pregnancy, being pregnant, going through delivery, and what to expect during baby's first year, we're here to guide you each step of the way. Learn more at **livinghealthybabies.com**.

Call-in Maternity Support

We offer specialized pregnancy and post-partum support to improve your health and help avoid complications. Call a Care Manager at **1-800-392-0098** Monday through Friday, 8:30 a.m. to 4:30 p.m. ET. For high-risk pregnancies, Nurse Care Managers are available.

Breast Pumps

New mothers can get a cost-free manual or dual electric breast pump. Learn more at **bluecrossma.com/breast-pump**.

Childbirth Course Reimbursement

Expectant mothers may be eligible for reimbursement up to $90 for completing a childbirth course. Check with your employer or call Member Service at the number on your ID card to see if you have this benefit.

Call-in Maternity Depression Care

Many women may experience anxiety, mood swings, and crying spells known as "baby blues," but these feelings usually go away in a week or two post-delivery. Others experience a more serious condition called postpartum depression, which can last up to a year. Our Maternity Depression program provides support, education, and treatment referral for pregnant women and new mothers who may be struggling with these symptoms. For help, call a Behavioral Health Care Manager at **1-800-524-4010**, **ext. 62398**, Monday through Friday, 8:30 a.m. to 4:30 p.m. ET.

Learn More

Get started at **bluecrossma.org/maternity**.

FIND CARE

24/7 Nurse Line

If you have concerns about a health issue, call the 24/7 Nurse Line. A nurse can answer your medical questions and help you decide where to get the right care. Call **1-888-247-BLUE (2583)**.

Find a Doctor

To find a doctor or hospital near you, use our **Find a Doctor & Estimate Costs** tool, or call **1-800-588-5507** for help, Monday through Friday, 8:00 a.m. to 9:00 p.m. ET.

MASSACHUSETTS

000977610 55-1235 (5/21)

MASSACHUSETTS

MIND AND BODY REIMBURSEMENT

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

Save up to

$300

per family per calendar year.

Qualified for Mind and Body Reimbursement:*

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

Not Qualified for Mind and Body Reimbursement:

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

Find a Qualified Provider and Save

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

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

GET REIMBURSED IN THREE EASY STEPS

1

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

2

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

3

Mail
Send the completed form to the address listed.

Questions?

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

*Practitioners must be licensed, certified, or accredited for a service to qualify for reimbursement.

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.

001100150 (9/21)

MASSACHUSETTS

MCC COMPLIANCE

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

001652563

55-0647 (6/22)

MASSACHUSETTS

GRANDFATHER STATUS

The Plan Sponsor believes that this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Act). As permitted by the Act, a grandfathered plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being grandfathered means the plan may not include certain consumer protections of the Act that apply to other plans, such as providing preventive health services without any cost sharing. However, a grandfathered plan must comply with certain other consumer protections of the Act, such as the elimination of annual and lifetime limits on most benefits.

Questions about which protections do or do not apply, and what causes a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at **1-781-314-3268**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a summary of the protections which do and do not apply to grandfathered health plans.

001652601

GF-ASC (6/22)

MASSACHUSETTS

GRANDFATHER STATUS

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001652601

GF-ASC (6/22)

MASSACHUSETTS

NONDISCRIMINATION NOTICE

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

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

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

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

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

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

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

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

001651238

55-1487 (6/22)

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

Arabic/ةيبر:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

001651831
55-1493 (6/22)