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		502590040 Retired Over 65

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
			N/A	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

163537 36-3630 (11/17)

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.

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MASSACHUSETTS

SUMMARY OF BENEFITS

MEDEX® 3

City of Waltham

This Medex plan provides benefits for:
- Medicare Part A and B Deductibles and Coinsurances
- Prescription Drugs
- OBRA Benefits

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

Sign in

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

QUESTIONS? CALL 1-800-258-2226. (TTY) 711.

The Member Service staff can assist you Monday through Friday, 8 a.m. to 6 p.m.
Medicare Office Telephone Number in Massachusetts: **1-800-MEDICARE (1-800-633-4227)**

This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance; however, the Commonwealth of Massachusetts has stated that enrollment in Original Medicare (Medicare Part A and Medicare Part B) satisfies these standards.

YOUR MEDICAL BENEFITS

	Medicare Provides	Medex Provides
Inpatient Care		
Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services[†]	• Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up[††]
Physician or other professional provider services	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance
Skilled nursing facility—participating with Medicare*	• Full coverage for days 1–20 • Coverage for days 21–100 after daily Part A coinsurance	• Full coverage of Medicare daily coinsurance for days 21–100 • $16 daily for days 101–365
Skilled nursing facility—not participating with Medicare*	No benefits	$16 daily for 365 days per benefit period
Outpatient Care		
Office visits, emergency services, surgery, radiation therapy, X-ray and lab tests, podiatrists' services, durable medical equipment, and cardiac rehabilitation services	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance
Blood glucose monitors and materials to test for the presence of blood sugar	80% of approved charges after annual Part B deductible for all diabetics	Full coverage of Medicare deductible and coinsurance
Urine test strips (Claims must be submitted on a Medex Subscriber Claim form)	No benefits	Covered to the same extent as brand-name prescription drugs
Chiropractor services	80% of approved charges after annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray	Full coverage of Medicare deductible and coinsurance for Medicare-approved charges only
Short-term rehabilitation – physical therapy, speech-pathology, and occupational therapy services approved by Medicare	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance

	Medicare Provides	Medex Provides
Mental Health and Substance Use Treatment		
Biologically based mental conditions**		
Inpatient admissions in a general or mental hospital	• Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance • Coverage for mental hospital admissions is limited to a 190 day lifetime maximum	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up††
Outpatient visits	80% of approved charges after annual Part B deductible	• When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When visits are not covered by Medicare, full coverage with no visit maximum
Non-biologically based mental conditions		
Inpatient admissions in a general hospital	• Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up††
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to a 190 day lifetime maximum	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • When Medicare benefits are used up, full coverage up to 120 days per benefit period (at least 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)††
Outpatient visits	80% of approved charges after annual Part B deductible	• When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year

† Dental services are not covered by Medicare, however, when your medical or dental condition requires an inpatient admission, Medex provides full coverage for hospital and participating dentist charges for surgical removal of unerupted teeth or teeth impacted in bone, and the extraction of seven or more permanent teeth.

†† The additional days are a combination of days in a general or mental hospital.

* A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

** Treatment of rape-related mental or emotional disorders for victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

	Medicare Provides	Medex Provides
Prescription Drugs		
At a designated retail pharmacy	Medicare does not provide coverage for prescription drugs used outside of the hospital. See your Medicare handbook for certain covered drugs.	After a $50 calendar-year deductible: • Full coverage (generic drugs) • 80% coverage (brand-name drugs)
Through the designated mail order pharmacy (up to a 90-day supply for each prescription or refill)	No benefits	Full coverage after a: • $2 copayment (generic drugs) • $15 copayment (brand-name drugs)

Preventive Services Approved by Medicare and Medex

Medicare provides coverage for certain preventive services at no cost to members. For the current list of covered preventive services, refer to your Medicare & You handbook or go to **medicare.gov**. Some preventive covered services are highlighted below.

- One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)
- One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests)
- One routine colonoscopy every two years for a high-risk member (Full coverage for tests)
- Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare (Full coverage for tests)
- Routine prostate cancer screening for members 50 or older including one (PSA) test and one digital rectal exam, per calendar year (Full coverage for exam if doctor accepts assignment, full coverage for PSA test)
- One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)
- One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)
- One baseline mammogram during the five year period a member is age 35-39 and one routine mammogram per calendar year for members age 40 and older (Full coverage for screening)
- One routine Pap smear test per calendar year (Full coverage for test)

Important Information

- Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.
- The Medicare inpatient deductible and coinsurance amounts are subject to change January 1 of each year.
- Benefits are available immediately upon your effective date.
- You are encouraged to use an Express Scripts Pharmacy℠ outside of Massachusetts. These pharmacies will file claims for you as long as you have your ID card with you.

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

March 2023

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 *

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.

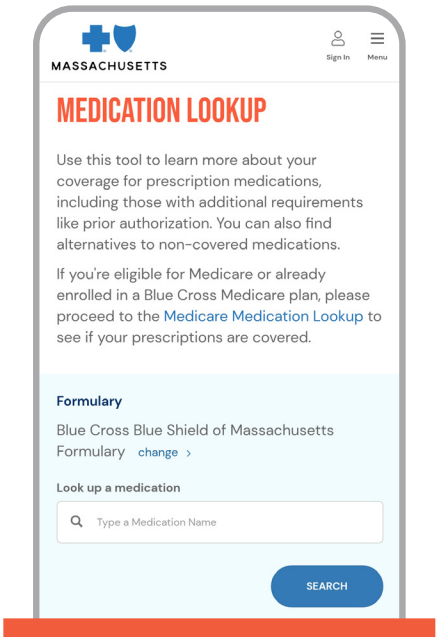
PERSONALIZED SEARCH

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.

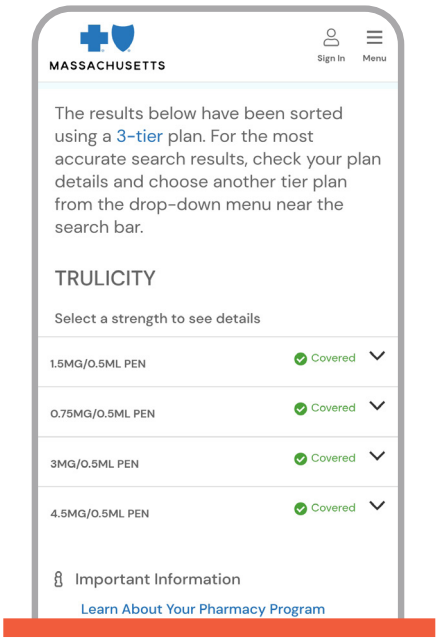
ANYONE CAN USE IT

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.

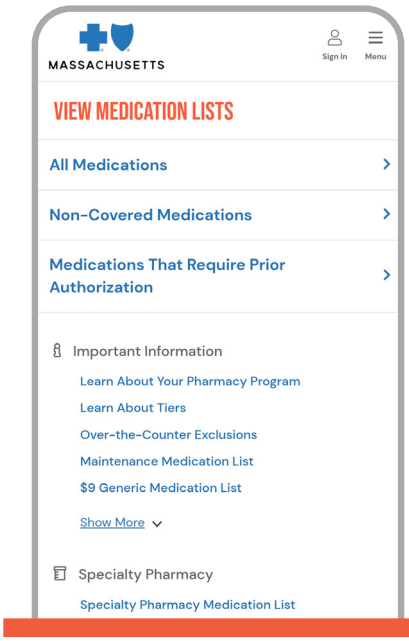
HOW TO USE THE TOOL



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.

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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.

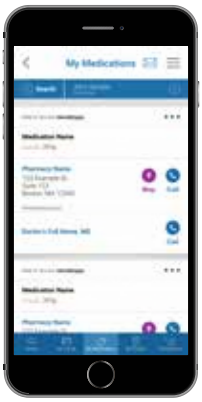
Personalized health care, right at their fingertips:

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.

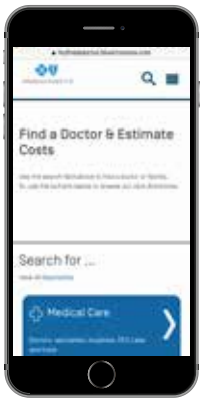
Get access to recent claims history and see copayment amounts.

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**).

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**).

MASSACHUSETTS

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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។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

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

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

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

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

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

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए 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, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

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

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