SUMMARY OF BENEFITS

Access Blue New England Saver

MIIA City of Pittsfield

MyBlue is a personalized way to access and manage your health plan. Get secure access to key plan information, claims history, and recent medications. Download or email a copy of your digital ID card. View your spending dashboard, important updates, alerts and notifications. Register or log in at bluecrossma.com/myblue or download the app on iTunes® or Google Play™.

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.

An Association of Independent Blue Cross and Blue Shield Plans
Your Care

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

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

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

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

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

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is $1,500 per individual membership (or $3,000 per family membership). The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, prescription drug copayments, and coinsurance for covered services. Your out-of-pocket maximum is $3,000 per member (or $6,000 per family).

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After meeting your deductible, you pay nothing per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
You are covered for certain medical and mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at wellconnection.com on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com, consult the Provider Directory, or call the Member Service number on your ID card.

Service Area

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

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

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child care visits</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Preventive care services</td>
<td></td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)</td>
<td>All charges beyond the maximum after deductible</td>
</tr>
<tr>
<td>Routine vision exams (one every 24 months)</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Family planning services—office visits</td>
<td>Nothing, no deductible</td>
</tr>
</tbody>
</table>

### Outpatient Care

<table>
<thead>
<tr>
<th>Emergency room visits</th>
<th>Nothing after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or health center visits</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Telehealth services for simple medical conditions or mental health</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Chiropractors’ office visits</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Acupuncture visits (up to 12 visits per calendar year)</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment—speech therapy</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Durable medical equipment—such as wheelchairs, crutches, and hospital beds</td>
<td>20% coinsurance after deductible**</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgery and related anesthesia in an office or health center</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit</td>
<td>Nothing after deductible</td>
</tr>
</tbody>
</table>

### Inpatient Care (including maternity care)

<table>
<thead>
<tr>
<th>General or chronic disease hospital care (as many days as medically necessary)</th>
<th>Nothing after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental hospital or substance use facility care (as many days as medically necessary)</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Rehabilitation hospital care (up to 60 days per calendar year)</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per calendar year)</td>
<td>Nothing after deductible</td>
</tr>
</tbody>
</table>

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

** Cost share waived for one breast pump per birth.
### Prescription Drug Benefits*

<table>
<thead>
<tr>
<th>Prescription Location</th>
<th>Your Cost**</th>
</tr>
</thead>
</table>
| At designated retail pharmacies*** (up to a 30-day formulary supply for each prescription or refill) | $10 after deductible for Tier 1  
$30 after deductible for Tier 2  
$65 after deductible for Tier 3 |
| Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill) | $25 after deductible for Tier 1 †  
$75 after deductible for Tier 2  
$165 after deductible for Tier 3 |

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.  
** Cost share may be waived for certain covered drugs and supplies.  
*** Specialty drugs available only when obtained from a designated specialty pharmacy.  
† Certain generic medications are available through the mail service pharmacy at $9, no deductible. For more information, go to bluecrossma.com/mail-service-pharmacy.

### Get the Most from Your Plan

Visit us at bluecrossma.com or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

<table>
<thead>
<tr>
<th>Wellness Participation Program</th>
<th>Details</th>
<th>Cost</th>
</tr>
</thead>
</table>
| **Fitness Reimbursement**    | a benefit that rewards participation in qualified fitness programs  
This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs. (See your benefit description for details.) | $150 per calendar year per policy |
| **Weight Loss Reimbursement** | a benefit that rewards participation in a qualified weight loss program  
This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.) | $150 per calendar year per policy |
| **24/7 Nurse Care Line**     | A 24-hour nurse line to answer your health care questions—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.com.  
Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at bluecrossma.com/myblue.

**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.
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.
Translation Resources
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 Menn nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/ difíc: انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف للصم والبكم TTY: 711).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ បានជួនដំណឹងភាសានេះ គឺអាចរកបានសុវត្ថិភាពដ៏ល្អជាងគេ៖ ការជូនដំណឹងភាសានេះមានសំរាប់អ្នក។ សូមទូរស័ព្ទបៅខ្្នកបសវាសរាជិកតាមបេ្ (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).


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 हिंदी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए मुफ्त 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 બોલતી હો છો, તો તમને ભાષાસહાય સેવાઓ બીજા મૂળભૂત છે. નમ્ભાય આઈડી કાર્ડ પર આપણી નંબર પર Member Service ને કોલ કરો (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ト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）。


