MEMORANDUM OF AGREEMENT
HEALTH INSURANCE

WHEREAS, the City Council of the City of Pittsfield voted on May 15, 2008 to accept M.G.L. c. 32B, §19, as amended by Chapter 67 of the Acts of 2007, (Section 19); and

WHEREAS the City of Pittsfield (hereinafter referred to as "City") and the duly-formed Public Employee Committee (hereinafter referred to as "PEC") has agreed to continue obtaining its health insurance from the Massachusetts Interlocal Insurance Association/BlueCross BlueShield Massachusetts (hereinafter referred to as "MIIA/BCBSMA"); and

WHEREAS, the City and PEC have negotiated terms and conditions relevant to this continued coverage;

NOW, THEREFORE, the City and the PEC agree as follows:

Effective Date and Duration of Agreement

1. The Agreement shall take effect on the date the City and the PEC execute the Agreement and shall remain in effect through June 30, 2024.

Health Insurance Benefit Changes

2. Effective July 1, 2018, and through June 30, 2020, all plans (HMO and PPO) will move to the MIIA/BCBSMA Benchmark v1 plan design. The Plan Design for each of these plans is attached and made part of this agreement as Exhibit A.

3. Effective July 1, 2020, and through June 30, 2022, all plans (HMO and PPO) will move to the MIIA/BCBSMA Benchmark v2 plan design. The Plan Design for each of these plans is attached and made part of this agreement as Exhibit B.

4. Effective July 1, 2022, and through June 30, 2024, all plans (HMO and PPO) will move to the MIIA/BCBSMA Benchmark v3 plan design. The Plan Design for each of these plans is attached and made part of this agreement as Exhibit C.

5. Effective July 1, 2018, in addition to the Fiscal Year 2018 health insurance plans offered to members through MIIA/BCBSMA, the following additional plans will be offered: a Health Savings Account ("HSA") qualified High Deductible Health Plan with a $1,500.00 Individual and a $3,000.00 Family Deductible and an Out of Pocket maximum of $3,000.00 Individual/$6,000.00 Family, including medical and prescription (RX), (HMO and PPO). The Plan Design for each of these High Deductible Plans is attached and made part of this Agreement as Exhibit D.

HSA Contribution

6. For the term of this Agreement, the City agrees to make an annual employer contribution of the plan deductible to an HSA for eligible and participating members, pursuant to the chart below. Any new hire who opts for the High Deductible Health Plan will get the same 6-year cycle of employer contributions beginning in the fiscal year they enter the plan.

FY	HSA Employer Contribution
19	100%
20	100%
21	75%
22	75%
23	50%
24	50%

7. All administrative costs for establishing and maintaining the HSA shall be provided by the City.

8. The PEC shall use up to 100% of its portion of the Healthcare Trust in FY 21-24 to supplement the Employer Contribution to the individual HSA from the percentage indicated above up to a maximum of 100% for individuals who are enrolled in a High Deductible plan in those years. The exact percentage shall be determined by the PEC each year this section is implemented.

Contribution Splits
HMO, PPO, High Deductible Plans Splits

9. For the duration of this Agreement, the City shall contribute the appropriate percent of the premium or cost for any HMO, PPO, or High Deductible plans offered by MIIA/BCBSMA as indicated in the chart below and the subscriber shall contribute remaining percent.

FY	HMO	PPO	High Deductible
19	83.5	83.5	85
20	82	82	85
21	82	82	85
22	81	81	85
23	81	81	85
24	80	80	85

If MIIA/BCBSMA offers any new or additional HMO, PPO, PPO-Type, and/or Indemnity plans during the life of this agreement, the same contribution rate shall apply.

Medicare Enrollment and Retiree Plan Splits

10. As soon practical, but no later than July 1, 2019, the City shall transfer all post-65 non-Medicare benefit eligible subscribers into Medicare Part A & B (a.k.a. Medicare buy-in) pursuant to applicable laws. The terms and conditions for reimbursement of Medicare fees and penalties, paid by the City, shall be subject of collective bargaining with the PEC. The agreed upon terms and conditions for reimbursement shall be added as an addendum to this agreement.

11. For the duration of this Agreement, the City shall contribute the eighty-five (85) percent of the premium cost for any plans offered by MIIA/BCBSMA and the subscriber shall contribute fifteen (15) percent as the pre-Medicare rate for the plan selected. If MIIA/BCBSMA offers any new or additional plans during the life of this agreement, the same contribution rate shall apply. The City does not contribute toward Medicare Part B coverage.

Future Meetings of City and PEC

12. The PEC shall be comprised of a representative of every collective bargaining unit who shall be appointed by the union President that negotiates with the City under M.G.L. c.150E, and a retiree representative designated by the Retired State, County and Municipal Employees Association. Each union representative and the retiree representative shall have the option of allowing one additional representative to attend meetings of the PEC and the City or their designee.

13. The parties shall establish a regular schedule of meetings to discuss the implementation of this Agreement and any issues relating to the effectiveness and efficiency of health coverage for subscribers. Such meetings shall take place quarterly, unless mutually agreed otherwise in writing. Meetings shall be held at times and places that are mutually agreed upon by the City and the PEC. In addition, either party may convene a meeting upon seven days' notice to the other party, unless there is an emergency that requires shorter notice. Meeting notices shall be provided to the City and to the PEC in writing. The City may provide notice of a meeting or a series of meetings up to twelve months in advance of a meeting. Any employee who is a representative of the PEC shall receive time off to attend meetings between the PEC and the City with full pay and benefits.

Wellness Committee

14. The PEC shall designate representatives to serve on the City's Employee Wellness Committee to help make informed recommendations relative to focus wellness initiatives against general cost drivers and coordinate subscriber educational initiatives.

Initial and Annual Accounting

15. The City will provide an accounting of both the Healthcare Trust and any remaining funds in the Employee Mitigation Fund after final disbursements are made (September 1, 2018, see previous PEC agreement). At that time the parties shall jointly determine how said funds will be used.

16. The City will provide annual account statements of both the relevant costs incurred via MIAA/BSBSMA and the Healthcare Trust account balance to the PEC.

Correspondence and Information

17. The City shall make available to the PEC copies of any correspondence between the City, the GIC, MIIA/BCBSMA or between the City and any provider of health care on a quarterly basis. Likewise, the PEC shall make all like correspondence from any healthcare provider available to the City within the same timeframe. Correspondence or information protected by HIPPA will remain confidential.

Health Insurance Coverage After June 30, 2024

18. The parties agree to complete a thorough cost and benefit review of the health plans with recommendations for potential changes in carrier and/or coverage, as done in 2017. If appropriate, the parties agree to place the health plans out to bid, no later than December 1, 2023 for a July 1, 2024 effective date. The bid request shall be jointly developed by the City and the PEC commencing no later than September 1, 2023. Costs associated with the review and/or the RFP shall be absorbed by the City. The review and/or the RFP shall compare or be issued to not less than three health insurance carriers and shall additionally include a cost and benefit comparison to the GIC and a self-funding option, unless mutually agreed to by the parties.

19. The City or its designee and the PEC shall begin negotiations for a successor agreement pursuant to Section 19 no later than February 1, 2024. If the parties have not reached a successor agreement by April 1, 2024, the terms of this Agreement shall constitute the terms of the successor agreement except that all of the terms contained herein shall be modified to be consistent with a termination date of June 30, 2030.

20. In accordance with the provisions of the successor agreement, the City shall notify MIIA/BCBSMA no later than April 1, 2024, either that subscribers shall continue coverage through MIIA/BCBSMA effective July 1, 2024, the interval specified in the Agreement, or that the City is withdrawing its subscribers effective July 1, 2024.

21. The parties shall meet for the purposes of impact bargaining in the event any healthcare plans are modified as a result of the Patient Affordable Care Act or other changes to healthcare effectuated by the government. In addition, either party may require a re-opener of this Memorandum of Agreement by giving the other party to the Agreement, a seven (7) calendar day advance notice. After the notice is given the parties will meet within seven (7) days to discuss any suggested changes to this Agreement.

Life and Dental Insurance

22. After subscribers are transferred to MIIA/BCBSMA, the City shall offer life insurance and dental insurance to subscribers at the same terms and contribution splits as were provided to group insurance participants prior to transfer to MIIA/BCBSMA.

Surviving Spouse Coverage

23. The parties agree that a surviving spouse will pay the same amount as the employee and/or retiree for health coverage in the event the employee and/or retiree dies.

Effect of Agreement

24. This Agreement shall be binding on all subscribers and shall supersede any conflicting provisions of any City policies, codes, or any collective bargaining agreements between the City, School Committee, and any unions representing City and/or School Committee employees.

Cancellation

25. In the event the City is delinquent in making payments as required by MIIA/BCBSMA and MIIA/BCBSMA notifies the City that it intends to exercise its option to cancel coverage pursuant to Section 19, the City shall immediately notify the PEC, present it a proposal for plans that are at least the actuarial equivalent of those offered by MIIA/BCBSMA, and engage in negotiations with the PEC for replacement coverage.

Arbitration of Disputes

26. Either party may submit a dispute between the parties concerning the interpretation or application of this Agreement to the American Arbitration Association for arbitration under its Labor Arbitration Rules. A request for arbitration by the PEC shall be in accordance with M.G.L. c. 32B, §19, as amended by Chapter 67 of the Acts of 2007, (Section 19).

Savings Clause

27. If any provision or portion of the Agreement is found to be unenforceable or unlawful, the remaining provisions or portions shall remain binding.

Scope and Modification

28. This Agreement shall constitute the whole of the Agreement between the City and the PEC. The Agreement may be modified only through a mutual agreement between the City and the PEC.

MEMORANDUM OF AGREEMENT
HEALTH INSURANCE

Dated: April 6, 2018

For the City of Pittsfield:

Linda M. Ayer

Chair, Pittsfield Public Employee Committee

For the Pittsfield Federation of School Employees, Local 1315:

For the Teamsters, Local 404:

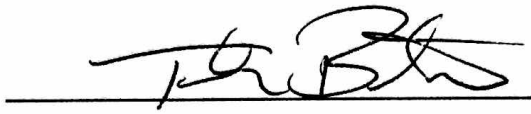
Lawrence E. Whitehead III

For the United Educators of Pittsfield:

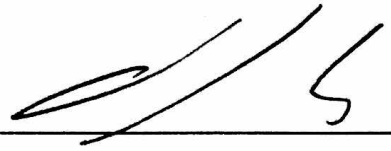
For the Pittsfield Educational Administrators Association:

MEMORANDUM OF AGREEMENT
HEALTH INSURANCE

For the International Association of Firefighters:



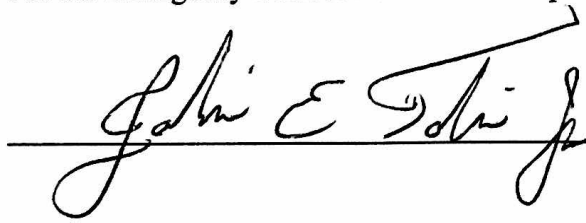
For the International Brotherhood of Police Officers, Local 447 Police:



For the International Brotherhood of Police Officers, Local 4475 Superior Officers:

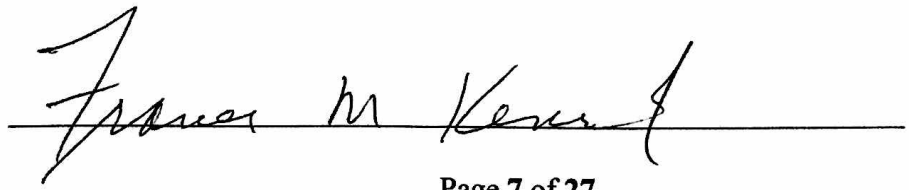
For the Pittsfield Supervisory and Professional Employees Association:

For the Emergency Telecommunication Dispatchers, I.U.E. CWA 81256:



For the Berkshire Athenaeum Employees Association:

For the Retired Employees of the City of Pittsfield:



Your Care

Your Primary Care Provider.

When you enroll in Network Blue New England, you must choose a primary care provider (PCP) who is available to accept you and your family members and participates in our network of providers throughout the New England states. For children, you may designate a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYNs: visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call our Physician Selection Service at 1-800-821-1388. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is probably someone affiliated with your PCP's hospital or medical group. You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield concerning referrals, and the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review and services requiring referral from your PCP is detailed in your benefit description.

Your Cost Share.

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive certain inpatient services at or by "higher cost share hospitals." See the chart on the opposite page for your cost share amounts.

Please note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain inpatient services at or by these hospitals, even if your PCP refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Boston Childrenl Centerwil
- Brigham and WomenCenterwill
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- North Shore Medical Center –Salem Campus
- North Shore Medical Center –Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

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

Your Deductible.

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

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is $2,500 per member (or $5,000 per family). Your out-of-pocket maximum for prescription drug benefits is $1,000 per member (or $2,000 per family).

Emergency Care – Wherever You Are.

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 the deductible, you pay a $100 copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

Service Area.

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

Outside the Service Area.

If you're traveling outside your service area and you need urgent or emergency care, go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please see your subscriber certificate 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. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost
Preventive Care	
Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Hearing Benefits	
Routine hearing exams	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum
Outpatient Care	
Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	 $20 per visit, no deductible $35 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible
Mental health and substance abuse treatment	$15 per visit, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia • Office setting – When performed by your PCP, OB-GYN, nurse practitioner, or nurse midwife – When performed by other network providers • Ambulatory surgical facility, hospital, or surgical day care unit	 $20 per visit,*** no deductible $35 per visit,*** no deductible $150 per admission after deductible
Inpatient care (including maternity care) • In other general hospitals (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	 $300 per admission after deductible† $700 per admission after deductible†
Mental hospital and substance abuse facility care (as many days as medically necessary)	$200 per admission after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This copayment applies to mental health admissions in a general hospital.

Prescription Drug Benefits	Your Cost*
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1** $25 for Tier 2 $50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $20 for Tier 1** $50 for Tier 2 $110 for Tier 3

* Cost share waived for certain orally-administered anticancer drugs.

** Cost share waived for birth control.

Get the Most from Your Plan.

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

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at www.bluecrossma.com.
Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to www.bluecrossma.com/email to sign up.

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. Please note: Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payment only and does not assume financial risk for claims.

Your Choice

Your Deductible.

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

When You Choose Preferred Providers.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive inpatient services at or by "yrvice cost share hospitals.p
See the chart on the back page for your cost share amounts.
Please note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, youvid still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you. It is also important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your preferred provider refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
- Call our Physician Selection Service at 1-800-821-1388

When You Choose Non-Preferred Providers

If you have not satisfied your deductible, your provider may ask you to pay the actual charge for your care at the time of your visit. After the plan-year deductible has been met, you pay 20 percent coinsurance for most out-of-network covered services. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the providerce actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out -of -Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your medical out-of-pocket maximumis $2,500 per member (or $5,000 per family) for in-network and out-of-network services combined. Your prescription drug out-of-pocket maximum is $1,000 per member (or $2,000 per family).

Emergency Room Services.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After your in-network deductible, you pay a $100 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.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. Information concerning Utilization Review is detailed in your benefit description and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

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. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics		
Plan-year deductible	$250 per member $750 per family	$400 per member $800 per family
Plan-year out-of-pocket maximum	$2,500 per member/$5,000 per family for in-network and out-of-network services combined	
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) • Two visits for age 2 • One visit per calendar year from age 3 through age 18	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services–office visits	Nothing, no deductible	20% coinsurance after deductible
Hearing Benefits Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum	20% coinsurance after deductible and all charges beyond the benefit maximum
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for an observation stay)	$100 per visit after in-network deductible (copayment waived if admitted or for an observation stay)
Office visits • When performed by a family or general practitioner, geriatric specialist, internist, licensed dietitian nutritionist, optometrist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician • When performed by other covered providers	$20 per visit, no deductible $35 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$15 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (excluding routine tests)	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per date of service after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Surgery and related anesthesia • Office setting – When performed by a family or general practitioner, geriatric specialist, internist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician – When performed by other covered providers • Ambulatory surgical facility, hospital, or surgical day care unit	$20 per visit,*** no deductible $35 per visit,*** no deductible $150 per admission after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth.
*** 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
Inpatient care (including maternity care)		
s In other general hospitals (as many days as medically necessary)	$300 per admission after deductible*	20% coinsurance after deductible
s In higher cost share hospitals (as many days as medically necessary)	$700 per admission after deductible*	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$200 per admission after deductible	20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Prescription Drug Benefits**		
Plan-year out-of-pocket maximum	$1,000 per member $2,000 per family	None
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1*** $25 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $20 for Tier 1*** $50 for Tier 2 $110 for Tier 3	Not covered

* This cost share applies to mental health admissions in a general hospital.
** Cost share waived for certain orally-administered anticancer drugs.
*** Cost share waived for birth control.

Get the Most from Your Plan.

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Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

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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.

Your Care

Your Primary Care Provider.

When you enroll in Network Blue New England, you must choose a primary care provider (PCP) who is available to accept you and your family members and participates in our network of providers throughout the New England states. For children, you may designate a participating network pediatrician as the PCP. For a list of participating PCPs or OB/GYNs: visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call our Physician Selection Service at 1-800-821-1388. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is probably someone affiliated with your PCPeonhospital or medical group. You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield concerning referrals, and the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review and services requiring referral from your PCP is detailed in your benefit description.

Your Cost Share.

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive certain inpatient services at or by "t or by benefits. .eferral froSee the chart on opposite page for cost share amounts.

Please note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive inpatient services at or by these hospitals, even if your PCP refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

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

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. Your deductible is $300 per member (or $900 per family).

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered medical services. Your out-of-pocket maximum for medical benefits is $2,500 per member (or $5,000 per family). Your out-of-pocket maximum for prescription drug benefits is $1,000 per member (or $2,000 per family).

Emergency Care—Wherever You Are.

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 the deductible, you pay a $100 copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay.

Service Area.

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

When Outside the Service Area.

If you're traveling outside your service area and you need urgent or emergency care, go to the nearest appropriate healthcare facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please 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. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics	
Plan-year deductible	$300 per member $900 per family
Plan-year out-of-pocket maximum	$2,500 per member $5,000 per family
Covered Services	**Your Cost**
Preventive Care Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams	Nothing, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Hearing Care Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Mental health and substance abuse treatment	$20 per visit, no deductible
Office visits • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	 $20 per visit, no deductible $60 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Surgery and related anesthesia in an office • When performed by your PCP or OB/GYN • When performed by other network providers	 $20 per visit**, no deductible $60 per visit**, no deductible
Diagnostic X-rays and other imaging tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible***
Prosthetic devices	Nothing after deductible
Home health care and hospice services	Nothing after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$250 per admission after deductible
Inpatient Care (including maternity care) • In other general hospitals (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	 $275 per admission after deductible† $1,500 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$275 per admission, no deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	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.

*** Cost share waived for one breast pump per birth.

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

Prescription Drug Benefits*	Your Cost
Plan-year out-of-pocket maximum	$1,000 per member $2,000 per family
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1** $30 for Tier 2 $65 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $25 for Tier 1** $75 for Tier 2 $165 for Tier 3

* Cost share waived for certain orally-administered anticancer drugs.
** Cost share waived for birth control.

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Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

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Your Choice

Your Deductible.

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. Your deductibles are $300 per member (or $900 per family) for in-network services and $400 per member (or $800 per family) for out-of-network services.

When You Choose Preferred Providers.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive inpatient services at or by "yrvice cost share hospitals.p
See the chart on the back page for your cost share amounts.
Please note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, youvid still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you. It is also important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your preferred provider refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Boston Childrenl Centerwil
- Brigham and WomenCenterwill
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
- Call our Physician Selection Service at 1-800-821-1388

When You Choose Non-Preferred Providers

If you have not satisfied your deductible, your provider may ask you to pay the actual charge for your care at the time of your visit. After the plan-year deductible has been met, you pay 20 percent coinsurance for most out-of-network covered services. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the providerce actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your medical out-of-pocket maximum is $2,500 per member (or $5,000 per family) for in-network and out-of-network services combined. Your prescription drug out-of-pocket maximum is $1,000 per member (or $2,000 per family).

Emergency Room Services.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After your in-network deductible, you pay a $100 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.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. Information concerning Utilization Review is detailed in your benefit description and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

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. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics		
Plan-year deductible	$300 per member $900 per family	$400 per member $800 per family
Plan-year out-of-pocket maximum	$2,500 per member/$5,000 per family for in-network and out-of-network services combined	
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) • Two visits for age 2 • One visit per calendar year from age 3 through age 18	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services–office visits	Nothing, no deductible	20% coinsurance after deductible
Hearing Care Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum	20% coinsurance after deductible
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for an observation stay)	$100 per visit after in-network deductible (copayment waived if admitted or for an observation stay)
Office visits • When performed by a family or general practitioner, geriatric specialist, internist, licensed dietitian nutritionist, optometrist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician • When performed by other covered providers	$20 per visit, no deductible $60 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$20 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (excluding routine tests)	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per date of service after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Surgery and related anesthesia • Office setting – When performed by a family or general practitioner, geriatric specialist, internist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician – When performed by other covered providers • Ambulatory surgical facility, hospital, or surgical day care unit	$20 per visit,*** no deductible $60 per visit,*** no deductible $250 per admission after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth.
*** 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
Inpatient care (including maternity care)		
• General hospital care (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	$275 per admission after deductible* $1,500 per admission after deductible*	20% coinsurance after deductible 20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$275 per admission, no deductible	20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drug Benefits**		
Plan-year out-of-pocket maximum	$1,000 per member $2,000 per family	None
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1*** $30 for Tier 2 $65 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$25 for Tier 1*** $75 for Tier 2 $165 for Tier 3	Not covered

* This cost share applies to mental health admissions in a general hospital.
** Cost share waived for certain orally-administered anticancer drugs.
*** Cost share waived for birth control.

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Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

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Your Care

Your Primary Care Provider (PCP)

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

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call the Physician Selection Service at 1-800-821-1388.

If you have trouble choosing a doctor, the Physician Selection 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.

Referrals

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

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

Your Cost Share

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

Note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your PCP refers you.

Higher Cost ShareHospitals

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

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

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

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

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for 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 $500 per member (or $1,000 per family). Your deductible for prescription drugs is $100 per member (or $200 per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is $2,500 per member (or $5,000 per family). Your out-of-pocket maximum for prescription drug benefits is $1,000 per member (or $2,000 per family).

Emergency Room Services

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

Telehealth Services

You are covered for certain medical and behavioral health services for conditions that can be treated through video visits from an approved Telehealth provider. These Telehealth services are available by using your computer or mobile device when you prefer not to make an in-person visit for any reason to a doctor or therapist. For a list of Telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call the Physician Selection Service at 1-800-821-1388.

Service Area

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

When Outside the Service Area

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

Dependent Benefits

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

Your Medical Benefits

Covered Services	Your Cost
Preventive Care	
Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits, when performed by: • Your PCP, OB/GYN physician, network nurse practitioner or nurse midwife • Other network providers	 $20 per visit, no deductible $60 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$20 per visit, no deductible
Mental health or substance abuse treatment	$10 per visit, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Diagnostic X-rays and lab tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office, when performed by: • Your PCP or OB/GYN physician • Other network providers	 $20 per visit***, no deductible $60 per visit***, no deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$250 per admission after deductible
Inpatient Care (including maternity care) in: • Other general hospitals (as many days as medically necessary) • Higher cost share hospitals (as many days as medically necessary)	 $275 per admission after deductible† $1,500 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$275 per admission, no deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	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.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital.

Prescription Drug Benefits*	Your Cost**
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 after deductible for Tier 1 $30 after deductible for Tier 2 $65 after deductible for Tier 3
Through the designated mail service 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

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

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Your Choice

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for 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 $500 per member (or $1,000 per family) for in-network services and $500 per member (or $1,000 per family) for out-of-network services. Your deductible for prescription drugs is $100 per member (or $200 per family).

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 est level of benefits.
This plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive certain inpatient services at or by "higher cost share hospitals." See the charts for your cost share.
Note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, yourvices (such as a specialist), make sure the provider is a preferredices at or by "higher cost share hospitals." See the charts for your co you.
Your cost will be greater when you receive certain inpatient services at or by the higher cost share hospitals listed below, even if your preferred provider refers you.

Higher Cost Share Hospitals

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

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

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

How to Find a Preferred Provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
- Call the Physician Selection Service at 1-800-821-1388

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 "ouriders, but your out-of-pocket costs are hi 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). See the charts for your cost share.

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is $2,500 per member (or $5,000 per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is $1,000 per member (or $2,000 per family).

Emergency Room Services

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

Telehealth Services

You are covered for certain medical and behavioral health services for conditions that can be treated through video visits from an approved Telehealth provider. These Telehealth services are available by using your computer or mobile device when you prefer not to make an in-person visit for any reason to a doctor or therapist. For a list of Telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call the Physician Selection Service at 1-800-821-1388.

Utilization Review Requirements

You must follow the requirements of Utilization Review, including Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. For detailed information about Utilization Review, see your benefit description. If you need non-emergency or non-maternity hospitalization, you, or someone on your behalf, must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield of Massachusetts and receive pre-approval, your benefits may be reduced or denied.

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.

Your Medical Benefits

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care Well-child care exams, including related 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) • Two visits for age 2 • One visit per calendar year age 3 and older	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests, (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services–office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits, when performed by: • Family or general practitioner, internist, OB/GYN physician, geriatric specialist, licensed dietitian nutritionist, optometrist, pediatrician, nurse practitioner, nurse midwife, physician assistant • Other covered providers	$20 per visit, no deductible $60 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$10 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible

Surgery and related anesthesia in an office, when performed by: • Family or general practitioner, internist, OB/GYN physician, geriatric specialist, pediatrician, nurse practitioner, nurse midwife, physician assistant • Other covered providers	$20 per visit***, no deductible $60 per visit***, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Ambulatory surgical facility, hospital, or surgical day care unit	$250 per admission after deductible	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
*** 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
Inpatient Care (including maternity care) • In other general hospitals (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	$275 per admission after deductible* $1,500 per admission after deductible*	20% coinsurance after deductible 20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$275 per admission, no deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drug Benefits** At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 after deductible for Tier 1 $30 after deductible for Tier 2 $65 after deductible for Tier 3	Not covered
Through the designated mail service 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	Not covered

* This cost share also applies to mental health admissions in a general hospital.
** Cost share may be waived for certain covered drugs and supplies.

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EXHIBIT D

MIIA HMO High Deductible Health Plan

7/1/2018 – 6/30/2024

BENEFIT	MIIA HMO HIGH DEDUCTIBLE HEALTH PLAN
Deductible	$1,500 / $3,000 (member / family)
Out of Pocket Maximum	Medical and Prescription Services: $3,000 Individual / $6,000 famlly
Preventtve Care Visit	$0
PCP Office Visit	Covered In fu ll after deductible
Specialist Office Visit	Covered In full after deductible
Emergency Room	Covered In fu ll after deductible
Inpatient Hospital Admission	Covered In full after deductible
Ambulatory Day/Outpatient Surgical Day	Covered In full after deductible
Dia1nostlc X-rays and LabTests, excludlng MRI's, CT and PET Sansand Nuclear Imaging	Covered in full after deductible
CT and PETscans and Nuclear Imaging	Covered in full after deductible
Short-Term Physical and Occupational Therapy	Covered In fun after deductible (up to 100 visits per CY)
Skilled Nursing Facility Care	Covered In full after deductible (up to 100 days per CY)
Speech Theropy	Covered In full after deductible
Home Health and Hospice Care	Covered In full after deductible
Durable Medical Equipment	Covered In fun after deductible
Chiropractic Services	Covered In full after deductible
Routine Vision Exam	Covered In full after deductible (one visit every 24 months)
Prescription Drug Deductible ($100 / $200) (applles to retail and mail) - Retail RX (up to 30-day supply) - Mail Order Drug RX (up to 90-day supply)	 applies to retail and mail $10/30/65 after deductible $25/75/165 after deductible

EXHIBIT D

MIIA PPO High Deductible Health Plan

7/1/2018 – 6/30/2024

BENEFIT	MIIA PPO HIGH DEDUCTIBLE HEALTH PLAN	MIIA PPO HIGH DEDUCTIBLE HEALTH PLAN
Network	In-Network	Out-Of-Network
Deductible	$1500 / $3000 (Member / Family) *	$1500 / $3000 (Member / Family) *
Out of Pocket Maximum	Medical and Prescription Services: $3000 Individual / $6000 Family	Mecical Services: Combined In and Out
Preventtve Care Visit	$0	20% coinsurance after deductible
PCP Office Visit	Covered in full after deductible	20% coinsurance after deductible
Specialist Office Visit	Covered in full after deductible	20% coinsurance after deductible
Emergency Room	Covered in full after deductible	Covered In full after deductible
Inpatient Hospital Admission	Covered in full after deductible	20% coinsurance after deductible
Ambulatory Day/Outpatient Surgical Day	Covered in full after deductible	20% coinsurance after deductible
Dia1nostlc X-rays and LabTests, excludlng MRI's, CT and PET Sansand Nuclear Imaging	Covered in full after deductible	20% coinsurance after deductible
MRI, CT and PETscans and Nuclear Imaging	Covered in full after deductible	20% coinsurance after deductible
Short-Term Physical and Occupational Therapy	Covered in full after deductible (up to 100 visits per CY)	20% coinsurance after deductible
Skilled Nursing Facility Care	Covered in full after deductible (up to 100 visits per CY)	20% coinsurance after deductible
Speech Theropy	Covered in full after deductible	20% coinsurance after deductible
Home Health and Hospice Care	Covered in full after deductible	20% coinsurance after deductible
Durable Medical Equipment	Covered in full after deductible	20% coinsurance after deductible
Chiropractic Services	Covered in full after deductible	20% coinsurance after deductible
Routine Vision Exam	Covered in full after deductible (one visit every 24 months)	20% coinsurance after deductible
Prescription Drug Deductible ($100 / $200) (applies to retail and mail) - Retail RX (up to 30-day supply) - Mail Order Drug RX (up to 90-day supply)	 applies to retail and mail $10/30/65 after deductible $25/75/165 after deductible	 applies to retail and mail $20/60/130 after deductible not covered