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 continue obtaining it's health insurance from the Massachusetts Interlocal Insurance Association/BlueCross BlueShield Massachusetts (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, 2030.

Health Insurance Benefit Changes

2. All plans (HMO and PPO) will be 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 A.

3. A Health Savings Account ("HSA") qualified High Deductible Health Plan with a $1,600.00 Individual and a $3,200.00 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 B.

HSA Contribution

4. For the term of this Agreement, the City agrees to make an annual employer contribution of the plan deductible to an HSA for current eligible and participating members, pursuant to the chart below.

FY	HSA Employer Contribution
25	50%
26	50%
27	25%
28	25%
29	0%
30	0%

Any new hire who opts for the High Deductible Health Plan will receive a 50% employer contribution beginning in the fiscal year they enter the plan and extending through the full term of this agreement.

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

Contribution Splits
HMO, PPO, High Deductible Plans Splits

6. 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.

HMO	PPO	High Deductible
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

7. 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.

Premium Holiday

8. In any year of this agreement when the average rate increase for non-Medicare plans is 6.5% or greater, all participants shall receive a one (1) month premium holiday.

Future Meetings of City and PEC

9. 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.

10. 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 annually, 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

11. 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

12. The City will provide annual account statements of both the relevant costs incurred via MIAA/BSBSMA. A PEC member may participate in the annual review of the City's health insurance program.

Correspondence and Information

13. 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, 2030

14. 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, 2029 for a July 1, 2030 effective date. The bid request shall be jointly developed by the City and the PEC commencing no later than September 1, 2029. 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.

15. The City or its designee and the PEC shall begin negotiations for a successor agreement pursuant to Section 19 no later than February 1, 2030. 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.

16. In accordance with the provisions of the successor agreement, the City shall notify MIIA/BCBSMA no later than April 1, 2029, 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.

17. 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

18. 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

19. 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

20. 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

21. 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

22. 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

23. 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

24. 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.
Dated: _____

For the City of Pittsfield:

_____

Chair, Pittsfield Public Employee Committee

_____

For the Pittsfield Federation of School Employees, Local 1315:

_____

For the Teamsters, Local 404:

For the United Educators of Pittsfield:

For the Pittsfield Educational Administrators Association:

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:

_____

BlueCross BlueShield | MIIA Nonprofit Locally based Member driven Serving Massachusetts' communities since 1982

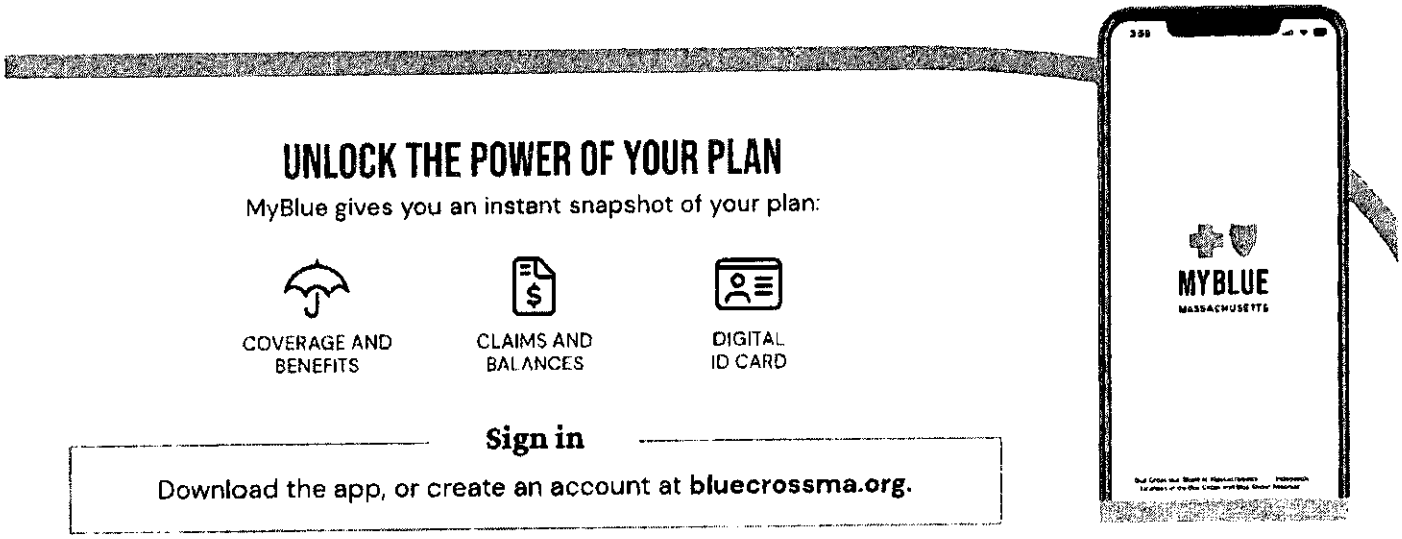
SUMMARY OF BENEFITS

MIIA City of Pittsfield

BLUE CARE ELECT $500 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

Plan-Year Deductible: $500/$1,000



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

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

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

YOUR CHOICE

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductibles for medical benefits are **$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 drug benefits 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 "in-network" benefits. See the charts for your cost share.

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

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

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

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

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

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

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

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

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

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical 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 in-network deductible, you pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

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

Your Virtual Care Team
Your health plan includes the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **For in-network outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For in-network outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your benefit description, or call the Member Service number on your ID card.

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

Value Care Offering Coverage
Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

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	[illegible]	[illegible]
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 for 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
[illegible]	[illegible]	[illegible]
Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for an observation stay)	$100 per visit after in-network deductible (copay not waived if admitted for an observation stay)
Office or health center visits, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, licensed dietitian nutritionist, optometrist, or by a physician assistant or nurse practitioner designated as primary care	$20 per visit, no deductible	20% coinsurance after deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$60 per visit, no deductible	20% coinsurance after deductible
Mental health or substance use treatment	$10 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the in-network designated telehealth vendor for simple medical conditions • With the in-network designated telehealth vendor for mental health services	Same as in-person visit $20 per visit, no deductible $10 per visit, no deductible	Same as in-person visit Only applicable in-network Only applicable in-network
Chiropractors' office visits (up to 30 visits per calendar year)	$20 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	$60 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 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	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per 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
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 or health center, when performed by • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care	$20 per visit***, no deductible	20% coinsurance after deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$60 per visit***, no deductible	20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$250 per admission after deductible	20% coinsurance after deductible
[illegible]	[illegible]	[illegible]
• Other general hospitals (as many days as medically necessary) • In-network higher cost share hospitals (as many days as medically necessary)	$275 per admission after deductible $1,600 per admission after deductible†	20% coinsurance after deductible Only applicable in-network
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$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

* 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, including supplies.

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

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

Covered Services		
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 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	Not covered

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

Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	$300 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	$300 per calendar year per policy
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	$300 per calendar year per policy

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

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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

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BlueCross® BlueShield®

MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

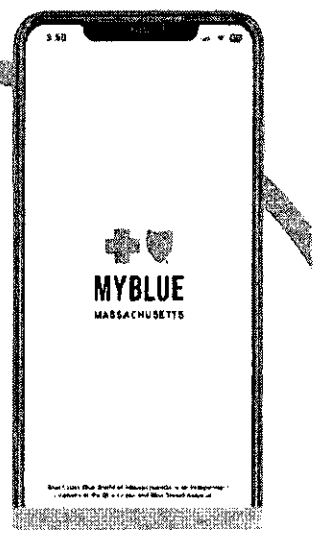
SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND $500 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

MIIA City of Pittsfield

Plan-Year Deductible: $500/$1,000



UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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

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

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

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

YOUR CARE

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

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

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

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

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

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

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

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

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

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

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible for medical benefits is **$500** per member (or **$1,000** per family). Your deductible for prescription drug benefits 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
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team
Your health plan includes the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **For outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your benefit description, or call the Member Service number on your ID card.

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.

Value Care Offering Coverage
Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

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	
Well-child care exams	**Nothing**, no deductible
Routine adult physical exams, including related tests	**Nothing**, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	**Nothing**, no deductible
Routine hearing exams, including routine tests	**Nothing**, no deductible
Hearing aids (up to $6,000 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
Emergency room visits	**$100** per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	**$20** per visit, no deductible **$60** per visit, no deductible
Mental health or substance use treatment	**$10** per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor for simple medical conditions • With the designated telehealth vendor for mental health services	**Same as in-person visit** **$20** per visit, no deductible **$10** per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year)	**$20** per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	**$60** 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	**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 or health center, when performed by: • Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	**$20** per visit***, no deductible **$60** per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	**$250** per admission after deductible
• Other general hospitals (as many days as medically necessary) • In-network 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 use 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, including supplies.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital

Covered Services	
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 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 brand-name drugs
** Cost share may be waived for certain covered drugs and supplies.

Wellness Participation Program **Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment** (See your benefit description for details.)	$300 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	$300 per calendar year per policy
Mind and Body Wellness Program **Reimbursement for participation in the Mind and Body Wellness Program** (See your benefit description for details.)	$300 per calendar year per policy

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

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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

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Covered Services	
Well-child care exams	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Emergency room visits	Nothing after deductible
Office or health center visits	Nothing after deductible
Mental health or substance use treatment	Nothing after deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit Nothing after deductible
Chiropractors' office visits	Nothing after deductible
Acupuncture visits (up to 12 visits per calendar year)	Nothing after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	Nothing after deductible
Speech, hearing, and language disorder treatment—speech therapy	Nothing after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia	Nothing after deductible
General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

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

Covered Services	
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 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 brand-name drugs.
** Cost share may be waived for certain covered drugs and supplies.

Wellness Participation Program	
Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	**$300** per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	**$300** per calendar year per policy
Mind and Body Wellness Program **Reimbursement for participation in the Mind and Body Wellness Program** (See your benefit description for details.)	**$300** per calendar year per policy

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

QUESTIONS?

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BlueCross® BlueShield®

MIIA Nonprofit Locally based Member owned
Serving Massachusetts' communities since 1982

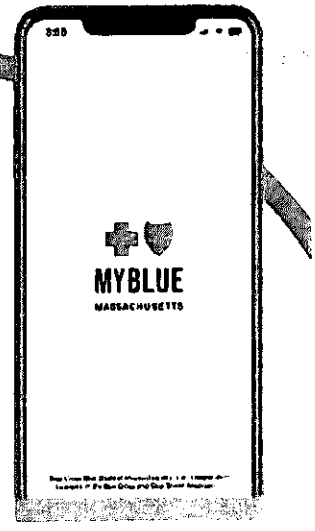
SUMMARY OF BENEFITS

ACCESS BLUE NEW ENGLAND SAVER

MIIA City of Pittsfield

1600 3200

Plan-Year Deductible: ~~$1,500~~/~~$3,000~~



UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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

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

YOUR CARE

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

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

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

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

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

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$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 for emergency room services.

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

Your Virtual Care Team
Your health plan includes the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **After meeting your deductible, for outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your benefit description, or call the Member Service number on your ID card.

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. 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	
Well-child care exams	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Emergency room visits	Nothing after deductible
Office or health center visits	Nothing after deductible
Mental health or substance use treatment	Nothing after deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit Nothing after deductible
Chiropractors' office visits	Nothing after deductible
Acupuncture visits (up to 12 visits per calendar year)	Nothing after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	Nothing after deductible
Speech, hearing, and language disorder treatment—speech therapy	Nothing after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia	Nothing after deductible
General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

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

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

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

Covered Services	
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 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 brand-name drugs.
** Cost share may be waived for certain covered drugs and supplies.

Wellness Participation Program	
Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	**$300** per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	**$300** per calendar year per policy
Mind and Body Wellness Program **Reimbursement for participation in the Mind and Body Wellness Program** (See your benefit description for details.)	**$300** per calendar year per policy

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

QUESTIONS?

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BlueCross® BlueShield®

MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

SUMMARY OF BENEFITS

BLUE CARE ELECT SAVER

MIIA City of Pittsfield

1600 3000

Plan-Year Deductible: $1,500/$3,000

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CLAIMS AND BALANCES

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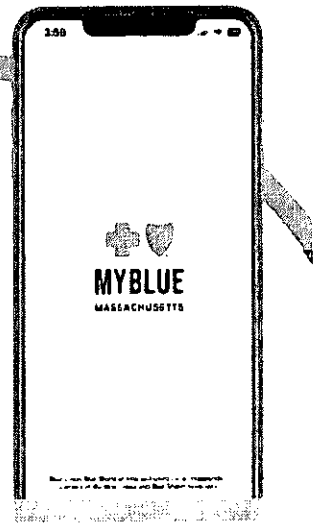

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CHOICE

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

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

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

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

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

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

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

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

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After meeting your in-network deductible, you pay nothing for in-network or out-of-network emergency room services.

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

Your Virtual Care Team
Your health plan includes the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team via traditional and/or digital platforms (such as: mobile app, web portal, telephone, and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. **After meeting your deductible, for in-network outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For in-network outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance).** To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see "When You Need Help to Find a Health Care Provider" in your benefit description, or call the Member Service number on your ID card.

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

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

Covered Services		
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 for age 3 and older	Nothing, no deductible	20% coinsurance, no deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance, no deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum after deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance, no deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance, no deductible
Emergency room visits	Nothing after deductible	Nothing after in-network deductible
Office or health center visits	Nothing after deductible	20% coinsurance after deductible
Mental health or substance use treatment	Nothing after deductible	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the in-network designated telehealth vendor	Same as in-person visit Nothing after deductible	Same as in-person visit Only applicable in-network
Chiropractors' office visits	Nothing after deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	Nothing after deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	Nothing after deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	Nothing after deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**	40% coinsurance after deductible
Prosthetic devices	Nothing after deductible	40% coinsurance after deductible
Surgery and related anesthesia	Nothing after deductible	20% coinsurance after deductible
General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth, including supplies

Covered Services		
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	$20 after deductible for Tier 1 $60 after deductible for Tier 2 $130 after deductible for Tier 3
Through the designated mail service 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	Not covered

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** Cost share may be waived for certain covered drugs and supplies.

Wellness Participation Program **Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment** (See your benefit description for details.)	$300 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	$300 per calendar year per policy
Mind and Body Wellness Program **Reimbursement for participation in the Mind and Body Wellness Program** (See your benefit description for details.)	$300 per calendar year per policy

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

QUESTIONS?

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