

ACCESS BLUE NEW ENGLAND SAVER

MIIA Town of Berkley

Plan-Year Deductible: \$2,000/\$4,000

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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 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 **\$2,000** per individual membership (or **\$4,000** 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, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical and prescription drug benefits is **\$6,450** per member (or **\$12,900** 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 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 an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

Value Care Offering Coverage

Your cost share may be waived for initial visits 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; physical and/or occupational therapy services; or services rendered by a dietitian/nutritionist specialist. See your benefit description (and riders, if any) for exact coverage details.

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 are 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	Your Cost
Preventive Care	
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
Mental health wellness exams (at least 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
Outpatient Care	
Emergency room visits	\$150 per visit after deductible (copayment waived if admitted or for an 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	\$25 per visit after deductible \$35 per visit after deductible
Mental health or substance use treatment	\$25 per visit after deductible
Outpatient telehealth services - With a covered provider - With the designated telehealth vendor	Same as in-person visit \$25 per visit after deductible
Chiropractors' office visits (up to 20 visits per calendar year)	\$35 per visit after deductible
Acupuncture visits (up to 12 visits per calendar year)	\$35 per visit after deductible
Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year*)	\$35 per visit after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$35 per visit after deductible
Diagnostic x-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$125 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	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance 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	\$25 per visit*** after deductible \$35 per visit*** after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$250 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$500 per admission 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 or Down syndrome.

** 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	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	After deductible \$10 for Tier 1 \$30 for Tier 2 \$65 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	After deductible \$25 for Tier 1 \$75 for Tier 2 \$165 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, reduced, or increased for certain covered drugs and supplies.	
Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	\$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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