BlueCross BlueShield

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

SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND $300 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

MIIA Town of Berkley

Plan-Year Deductible: $300/$900

TAP INTO YOUR HEALTH PLAN

MyBlue is your online member account that makes understanding and using your health plan simple.

- Track claims and benefits
- Find personalized care options
- View your member ID card

Get started

Sign in or create an account today. Download the app or visit **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 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 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 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. 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.

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	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 $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 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	$20 per visit, no deductible $60 per visit, no deductible
Mental health or substance use treatment	$20 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit $20 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
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 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 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.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
Prescription Drug Benefits*	
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 or designated retail 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

* 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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