

# NETWORK BLUE® NEW ENGLAND

Town of Wilmington

## 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](http://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

## 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](http://bluecrossma.org); consult Find a Doctor at [bluecrossma.com/findadoctor](http://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 Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for copayments and coinsurance for covered services. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your out-of-pocket maximum for medical benefits is **\$2,000** per member (or **\$4,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$4,450** per member (or **\$8,900** 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). 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](http://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.

## Service Area

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

## When Outside the Service Area

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

## Dependent Benefits

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

Covered Services	Your Cost
<b>Preventive Care</b>	
Well-child care exams	Nothing
Routine adult physical exams, including related tests	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing
Mental health wellness exams (at least one per calendar year)	Nothing
Routine hearing exams, including routine tests	Nothing
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing
Family planning services—office visits	Nothing
<b>Outpatient Care</b>	
Emergency room visits	\$125 per visit (waived if admitted or for observation stay)
Office or health center visits, when performed by: <ul style="list-style-type: none"> <li>Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care</li> <li>Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</li> </ul>	\$20 per visit \$35 per visit
Mental health or substance use treatment	\$20 per visit
Outpatient telehealth services <ul style="list-style-type: none"> <li>With a covered provider</li> <li>With the designated telehealth vendor</li> </ul>	Same as in-person visit \$20 per visit
Chiropractors' office visits	\$35 per visit
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$35 per visit
Speech, hearing, and language disorder treatment—speech therapy	\$35 per visit
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing
Home health care and hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**
Prosthetic devices	Nothing
Surgery and related anesthesia in an office or health center, when performed by: <ul style="list-style-type: none"> <li>Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care</li> <li>Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</li> </ul>	\$20 per visit*** \$35 per visit***
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission
<b>Inpatient Care (including maternity care)</b>	
General or chronic disease hospital care (as many days as medically necessary)	\$250 per admission
Mental hospital or substance use facility care (as many days as medically necessary)	\$250 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing

\* 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	Your Cost
<b>Prescription Drug Benefits*</b>	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	\$15 for Tier 1 \$25 for Tier 2 \$40 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	\$15 for Tier 1 \$25 for Tier 2 \$40 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 or reduced for certain covered drugs and supplies.

**Get the Most from Your Plan: Visit us at [bluecrossma.org](https://bluecrossma.org) or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.**

<b>Wellness Participation Program</b> Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	\$150 per calendar year per policy
<b>Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program</b> (See your benefit description for details.)	\$150 per calendar year per policy
<b>Mind and Body Wellness Program</b> 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](https://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: acupuncture visits; 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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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, see [www.bluecrossma.com](http://www.bluecrossma.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-782-3675 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For medical benefits, \$2,000 member / \$4,000 family; and for <u>prescription drug</u> benefits, \$4,450 member / \$8,900 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
	<u>Specialist visit</u>	\$35 / visit; \$35 / chiropractor visit; Not covered / acupuncture visit	Not covered	A telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	<u>Pre-authorization</u> required for certain services
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a>	Generic drugs	\$15 / retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived or reduced for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$25 / retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$40 / retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; <u>cost share</u> may be waived or reduced for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 / admission	Not covered	<u>Pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Pre-authorization</u> required for certain services
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$125 / visit	\$125 / visit	<u>Copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$35 / visit	\$35 / visit	Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 / admission	Not covered	<u>Pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Pre-authorization</u> / authorization required for certain services
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$250 / admission	Not covered	<u>Pre-authorization</u> / authorization required for certain services
<b>If you are pregnant</b>	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$250 / admission	Not covered	



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not covered	<u>Pre-authorization</u> required
	<u>Rehabilitation services</u>	\$35 / visit for outpatient services; No charge for inpatient services	Not covered	Limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$35 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	No charge	Not covered	Limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
	<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered
Children's glasses		Not covered	Not covered	None
Children's dental check-up		No charge for members with a cleft palate / cleft lip condition	Not covered	Limited to members under age 18

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$150 per calendar year per policy)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or [www.mass.gov/doi](http://www.mass.gov/doi). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's [marketplace](#), if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting [www.mahealthconnector.org](http://www.mahealthconnector.org). For more information on your rights to continue your employer coverage, contact your [plan](#) sponsor. (A [plan](#) sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your [plan](#) sponsor. (A [plan](#) sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Does this [plan](#) provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this [plan](#) meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Disclaimer:** This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care [plan](#). It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network prenatal care and a hospital delivery)

- **The plan's overall deductible** \$0
- **Delivery fee copay** \$0
- **Facility fee copay** \$250
- **Diagnostic tests copay** \$0

**This EXAMPLE event includes services like:**  
Specialist office visits (prenatal care)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (ultrasounds and blood work)  
Specialist visit (anesthesia)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$360</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$0
- **Specialist visit copay** \$35
- **Primary care visit copay** \$20
- **Diagnostic tests copay** \$0

**This EXAMPLE event includes services like:**  
Primary care physician office visits (including disease education)  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow-up care)

- **The plan's overall deductible** \$0
- **Specialist visit copay** \$35
- **Emergency room copay** \$125
- **Ambulance services copay** \$0

**This EXAMPLE event includes services like:**  
Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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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.

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MASSACHUSETTS

# HMO BLUE NEW ENGLAND

## IMPORTANT INFORMATION ABOUT YOUR PLAN

Your health plan lets you get care from providers who participate in the **HMO Blue New England Network**. Under this plan, you're required to choose a primary care provider (PCP) to manage your care and refer you to specialists.



## HOW TO ACCESS IMPORTANT RESOURCES

We're committed to your health—that's why we offer additional programs, benefits, and discounts beyond traditional health care coverage. Use these tools and resources to monitor your health and overall wellness.

**Unlock the Power of Your Plan:** MyBlue is your key to more features and savings. Plus, you can track your claims, medications, account balances, and more. To create an account, go to [bluecrossma.org](https://bluecrossma.org) or download the MyBlue app.

**Let Team Blue Lend a Hand:** Your health plan comes with a special feature: a coordinated team, ready to spring into action whether you need help understanding your coverage or getting the care you need. Need answers, access, or advice? Just ask. Call **1-800-262-2583**.

**Get Exclusive Health and Wellness Deals:** Blue365® offers great discounts and deals on sportswear, nutrition, travel, fitness equipment, and more. Explore available deals at [blue365deals.com](https://blue365deals.com).

## Need to Find a Doctor?

Go to [bluecrossma.org](https://bluecrossma.org) to use the **Find a Doctor** tool. To search for an in-network doctor, specialist, or hospital near you, select the network: **HMO Blue New England**.

## ACCESSING CARE

**The Importance of a Primary Care Provider:** Routine health checkups with your PCP are one of the best ways you can stay on top of your health. Your PCP can also manage your care and refer you to specialists.

Choose a PCP for yourself and every member of your family covered under your plan. Everyone doesn't need to see the same PCP.

When selecting a PCP, consider the hospital where your PCP has admitting privileges. You can use the **Find a Doctor** tool to find this information.

**Seeing a Specialist:** If you need to see a specialist, your PCP must refer you for the care to be covered under your plan. Make sure your PCP has contacted the specialist's office and provided the referral.

**Telehealth Visits:** When appropriate, you can choose to have phone or video visits with covered medical and mental health care providers. Ask your provider if they offer telehealth.

**24/7 Nurse Line:** Speak to a registered nurse, right when you need to, day or night. Call **1-888-247-BLUE (2583)**.

## UNDERSTANDING PRIOR AUTHORIZATION

To make sure you only get care that's medically necessary and covered by your plan, your doctor needs to obtain prior authorization, or approval, from us for certain services, procedures, or medications. Without prior authorization, your care may not be covered, and you may have to pay the full cost. Be sure to ask your doctor if prior authorization is needed before you receive care.

## ABOUT YOUR ID CARD

You need to show your member ID card when you go to the doctor or a hospital. It includes important details, such as copay amounts and your member ID number.\* If you have pharmacy coverage, this will be noted, too. You can use the MyBlue app to view, download, and email a digital version of your card.

Lost your ID card?  
No problem, you can order another one through MyBlue.

\*As of January 1, 2022, your ID card will also include information about the maximum deductible and out-of-pocket costs for your plan.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).