BlueCross® BlueShield®

SUMMARY OF BENEFITS

BLUE CARE ELECT PREFERRED

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.**

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

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.

You must pay a plan-year deductible before you can receive coverage for certain out-of-network benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$250** per member (or **$500** per family).

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 **$2,000** per member (or **$4,000** per family) for in-network and out-of-network services combined. 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 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 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.

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	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: • Ten 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	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance after deductible
Mental health wellness exams (at least one per calendar year)	Nothing	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing	20% coinsurance after deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$125 per visit (waived if admitted or for observation stay)	$125 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits	$25 per visit	20% coinsurance after deductible
Mental health or substance use treatment	$25 per visit	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the in-network designated telehealth vendor	 Same as in-person visit $25 per visit	 Same as in-person visit Only applicable in-network
Chiropractors' office visits	$25 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$25 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$25 per visit	20% coinsurance after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance after deductible**
Prosthetic devices	Nothing	20% coinsurance after deductible
Surgery and related anesthesia • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit	 $25 per visit*** $150 per admission	 20% coinsurance after deductible 20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	$250 per admission	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$250 per admission	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	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 (20% coinsurance after deductible out-of-network).
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
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	Not covered
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	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 or reduced 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.)	$150 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.)	$150 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: 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._____.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** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 in-network; $250 member / $500 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency room and emergency transportation.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, $2,000 member / $4,000 family; and for prescription drug benefits, $4,450 member / $8,900 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Specialist visit	$25 / visit; $25 / chiropractor visit; Not covered / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; Not covered / acupuncture visit	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; cost share waived for at least one mental health wellness exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required

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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$15 / retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization 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	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$125 / visit	$125 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$25 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable

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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$250 / admission	20% coinsurance	Deductible applies first for out-of-network; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first for out-of-network; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$250 / admission	20% coinsurance	

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)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Rehabilitation services	$25 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first for out-of-network; limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$25 / visit	20% coinsurance	Deductible applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies first for out-of-network; in-network cost share waived for one breast pump per birth, including supplies (20% coinsurance for out-of-network)
	Hospice services	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services

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)	
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% coinsurance for members with a cleft palate / cleft lip condition	Deductible applies first for out-of-network; 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
- 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
- Non-emergency care when traveling outside the U.S.
- 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 and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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. 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 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. 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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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	$25
■ Primary care visit copay	$25
■ 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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$25
■ 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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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

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MCC COMPLIANCE

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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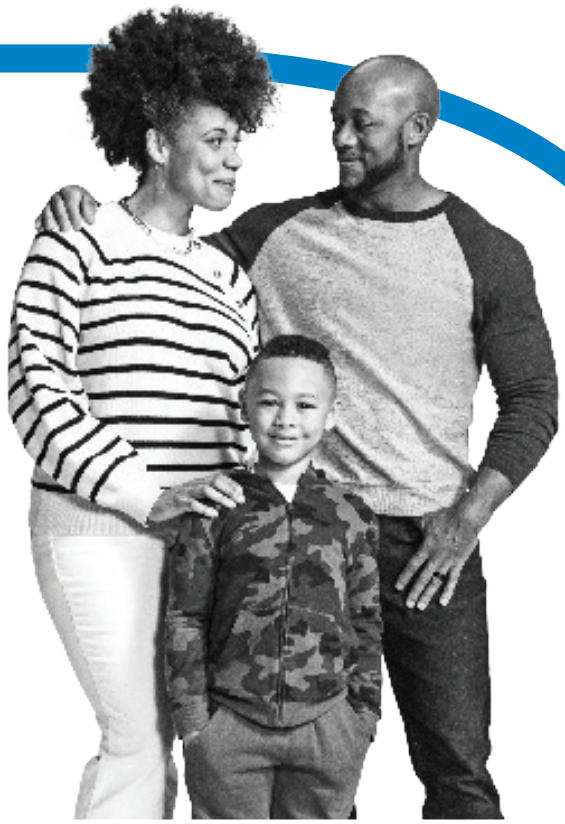

PREFERRED PROVIDER ORGANIZATION (PPO)

IMPORTANT INFORMATION ABOUT YOUR PLAN

Your health plan lets you get care from providers who participate in the **Blue Cross Blue Shield PPO Network** (preferred), as well as from providers who are out of our network. You'll pay lower out-of-pocket costs for care when you see in-network providers, and higher out-of-pocket costs when you see out-of-network providers.

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

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**.

Need to Find a Doctor?

1. Go to **bluecrossma.org** 2. Click **Find a Doctor** under **Find Care**
3. Enter a provider or type of care, then select the **PPO or EPO** network

ACCESSING CARE

Routine health checkups are one of the best ways you and your doctor can stay on top of your health. When selecting a doctor, consider the hospital where that doctor has admitting privileges.

Finding a Provider: You don't have to choose a primary care provider (PCP) to help manage your care, but you should see in-network doctors to pay the lowest out-of-pocket costs. You can also see out-of-network doctors, but you'll pay higher out-of-pocket costs.

Seeing a Specialist: You don't need a referral from your PCP to see a specialist. However, you should talk with your doctor about the specialty care you may need.

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

Show your member ID card every time you get care. Your ID card includes important information, such as your ID number, copay amounts, and if you have pharmacy coverage.* You can also download the MyBlue app and use it to email a digital version of your card to your doctor, or order a new ID card.

*As of January 1, 2022, your ID card also includes 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**).

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