MASSACHUSETTS

Cape Cod Municipal Health Group 2018
Plan Effective Date: 7/1/2018

Visit: http://planinfo.bluecrossma.com/ekit/2018-capecodmunicipalhealthgroup2018-en_US.pdf

Plan details: (click to view documents)	Plan documents		Online Resources
Blue Care Elect Deductible		SBC	Learn more about plan features
Blue Care Elect Saver		SBC	Learn more about plan features
Network Blue Deductible		SBC	Learn more about plan features
Access Blue New England Saver		SBC	Learn more about plan features

Learn more about:

- Plan Options
- Wellness
- Resources

Get more details on your plan (click to view documents)

Quick Start - Access Blue New England	Download
Quick Start - PPO	Download
Mail Service Pharmacy Brochure & Form	Download
$9 Generic Medications List	Download
Emergency Room Alternatives	Download
Health Savings Account (HSA) Fact Sheet (2017)	Download
ahealthyme	Download
Fitness Benefit	Download
Weight Loss Benefit	Download
Nurse Hotline	Download
MyBlue Member App	Download

PRIVATE NCQA HEALTH INSURANCE PLAN RATINGS 2016 - 2017

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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.ccmhg.com/blue-cross-blue-shield**.
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 **www.bluecrossma.com/sbcglossary** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** individual contract / **$4,000** family contract in-network; **$2,000** individual contract / **$4,000** family contract 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network prenatal care; preventive care, preventive drugs.	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?	**$5,000** member / **$10,000** 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 www.bluecrossma.com/findadoctor or call 1-800-821-1388 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	No charge	20% coinsurance	Deductible applies first
	Specialist visit	No charge; No charge / chiropractor visit	20% coinsurance; 20% coinsurance / chiropractor visit	Deductible applies first
	Preventive care/screening/immunization	No charge	20% coinsurance	Limited to age-based schedule and / or frequency. 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
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first; pre-authorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications	Generic drugs	$10 / retail supply or $25 / mail service supply	$20 / retail supply and all charges for mail service	Deductible applies first except for preventive drugs; up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / mail service supply	$60 / retail supply and all charges for mail service	
	Non-preferred brand drugs	$65 / retail supply or $165 / mail service supply	$130 / retail supply and all charges for mail service	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first; when obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first

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		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge	No charge	In-network deductible applies first for in-network and out-of-network services
	Emergency medical transportation	No charge	No charge	In-network deductible applies first for in-network and out-of-network services
	Urgent care	No charge	20% coinsurance	Deductible applies first
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Deductible applies first; pre-authorization required
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If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; 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)
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	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; pre-authorization required
	Rehabilitation services	No charge	20% coinsurance	Deductible applies first; limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	No charge	20% coinsurance	Deductible applies first; rehabilitation therapy coverage limits apply; coverage limits waived for early intervention services for eligible children
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	20% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth
	Hospice services	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Limited to one exam per calendar year
	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	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 per calendar year)
- 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Member Service number listed on your ID card 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]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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**	**$2,000**
■ **Delivery fee copay**	**$0**
■ **Facility fee copay**	**$0**
■ **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	**$12,713**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$16
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,076**

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

■ **The plan's overall deductible**	**$2,000**
■ **Specialist visit copay**	**$0**
■ **Primary care visit copay**	**$0**
■ **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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$1,154
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,209**

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

■ **The plan's overall deductible**	**$2,000**
■ **Specialist visit copay**	**$0**
■ **Emergency room copay**	**$0**
■ **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	**$1,925**

In this example, Jacquie would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Jacquie would pay is	**$1,925**

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

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MCC Compliance

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If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first; pre-authorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications	Generic drugs	$10 / retail supply or $25 / mail service supply	$20 / retail supply and all charges for mail service	Deductible applies first except for preventive drugs; up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / mail service supply	$60 / retail supply and all charges for mail service	
	Non-preferred brand drugs	$65 / retail supply or $165 / mail service supply	$130 / retail supply and all charges for mail service	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first; when obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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If you need immediate medical attention	Emergency room care	No charge	No charge	In-network deductible applies first for in-network and out-of-network services
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	Urgent care	No charge	20% coinsurance	Deductible applies first
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If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; 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)
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first; pre-authorization required
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	Skilled nursing care	No charge	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
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	Hospice services	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
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(9 months of in-network prenatal care and a hospital delivery)

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Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,209**

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

■ **The plan's overall deductible**	**$2,000**
■ **Specialist visit copay**	**$0**
■ **Emergency room copay**	**$0**
■ **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	**$1,925**

In this example, Jacquie would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Jacquie would pay is	**$1,925**

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MCC Compliance

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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.ccmhg.com/blue-cross-blue-shield**.
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 **www.bluecrossma.com/sbcglossary** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** member / **$600** two-person / **$900** family.	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. Preventive care, prenatal care, prescription drugs, most office visits, mental health visits, and therapy visits.	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, **$3,000** member / **$6,000** 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 http://www.bluecrossma.com/findadoctor or call 1-800-821-1388 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$20 / visit	Not covered	None
	Specialist visit	$45 / visit; Not covered / chiropractor visit	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year. 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	Not covered	Deductible applies first
	Imaging (CT/PET scans, MRIs)	$100	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications	Generic drugs	$10 / retail supply or $25 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / mail service supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization 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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$45 / visit	$45 / visit	Out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Inpatient services	$500 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$500 / 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)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / visit	Not covered	Limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services
	Habilitation services	$20 / visit	Not covered	Rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Deductible applies first; cost share waived for one breast pump per birth
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

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
- Chiropractic care
- 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
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 12 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Member Service number listed on your ID card 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]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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** **$300**
- **Delivery fee copay** **$0**
- **Facility fee copay** **$500**
- **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	**$12,713**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$516
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$876**

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

- **The plan's overall deductible** **$300**
- **Specialist visit copay** **$45**
- **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)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$134
Copayments	$1,674
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,863**

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

- **The plan's overall deductible** **$300**
- **Specialist visit copay** **$45**
- **Emergency room copay** **$100**
- **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	**$1,925**

In this example, Jacquie would pay:

Cost Sharing	
Deductibles	$300
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Jacquie would pay is	**$550**

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

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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 **www.bluecrossma.com/sbcglossary** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** individual contract / **$4,000** family contract.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and prenatal care, preventive drugs.	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?	**$5,000** member / **$10,000** 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 www.bluecrossma.com/findadoctor or call **1-800-821-1388** 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	No charge	Not covered	Deductible applies first
	Specialist visit	No charge; No charge / chiropractor visits	Not covered	Deductible applies first
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year. 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	Not covered	Deductible applies first
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications	Generic drugs	$10 / retail supply or $25 / mail service supply	Not covered	Deductible applies first except for preventive drugs; up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $75 / mail service supply	Not covered	
	Non-preferred brand drugs	$65 / retail supply or $165 / mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	Deductible applies first; when obtained from a designated specialty pharmacy; pre-authorization 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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	No charge	No charge	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	No charge	No charge	Deductible applies first; out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Inpatient services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	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)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	No charge	Not covered	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services
	Habilitation services	No charge	Not covered	Deductible applies first; rehabilitation therapy coverage limits apply; coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	Not covered	Deductible applies first; cost share waived for one breast pump per birth
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

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 per calendar year)
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Does this plan provide Minimum Essential Coverage? [Yes]
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Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

■ **The plan's overall deductible**	**$2,000**
■ **Delivery fee copay**	**$0**
■ **Facility fee copay**	**$0**
■ **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	**$12,713**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$16
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,076**

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

■ **The plan's overall deductible**	**$2,000**
■ **Specialist visit copay**	**$0**
■ **Primary care visit copay**	**$0**
■ **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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$1,154
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,209**

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

■ **The plan's overall deductible**	**$2,000**
■ **Specialist visit copay**	**$0**
■ **Emergency room copay**	**$0**
■ **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	**$1,925**

In this example, Jacquie would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Jacquie would pay is	**$1,925**

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

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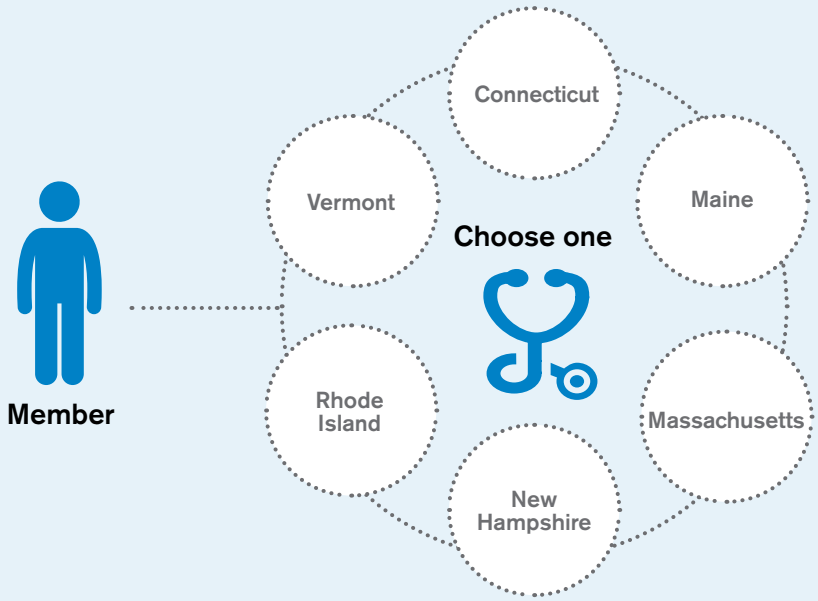
Quick Start Guide

Access Blue New England

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Access

Access Blue New England gives you the option to go directly to any specialist or doctor in the HMO Blue New England network. No referrals needed. Just show your ID card and receive care. Some services require prior authorizations.



Your Primary Care Provider

As a member of our Access Blue New England health plan, you must choose a primary care provider (PCP) for you and each member of your family. You can choose from any of the health care provider networks in the six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont). Having a PCP who knows the health history of you and your family makes good health sense. Also, your out-of-pocket costs for some services will be less when you visit your PCP.

To Find a PCP, You Can:

- Visit our website at **bluecrossma.com/findadoctor**
- Call our Physician Selection Service at **1-800-821-1388**

To Find Providers

To find a doctor, dentist, behavioral health provider, hospital, or other health care provider, you can:

- Visit our website at **bluecrossma.com/findadoctor**
- Call Member Service at the number on the front of your ID card

Emergency Care

If you have a medical or behavioral health emergency, call **911** (or your local emergency number) or go directly to the nearest medical facility. Be sure to contact your PCP within 48 hours, so that he or she can evaluate your condition and coordinate any follow-up care.

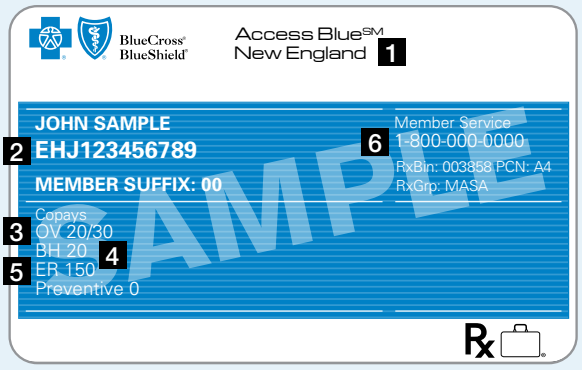
BlueCard® Program

Your Blue Cross card is widely recognized, and the BlueCard program allows you to receive urgent and emergency care services from any hospital or health care provider in the United States that participates in a Blue Cross plan. For a listing of participating health care providers and hospitals, call **1-800-810-BLUE (2583)**. For more information, visit the BlueCard website at **provider.bcbs.com**.

Know How to Read Your ID Card

Your member ID card contains important information, including our Member Service telephone number, your ID number, and your plan's copay for office visits, behavioral health visits, and emergency room visits. Be sure to always carry your ID card with you, and show it to all of your providers so they can update your records.

To the right is a sample ID card. Information shown on your ID card may be different based on your plan benefits. Check your ID card for your specific copay amounts.



1. Plan name
2. Your ID number
3. Office visit copay for designated PCP, obstetrician, gynecologist, nurse practitioner, nurse midwife, or any other network provider
4. Behavioral health office visit copay
5. Emergency room copay (waived if admitted)
6. Number to call for questions about your plan

Get the Most from Your Plan

MyBlue

An easier way to access your health care plan and claims information. You can:

- View detailed plan information (benefits, deductible)
- View health financial accounts
- Access claims and review history in one convenient spot
- Quickly access commonly used tools and services

Register or log in now at **bluecrossma.com/myblue.**

ahealthyme®—Everything to Live a Healthier Life

Here you'll find interactive tools and comprehensive information that will help you assess your health and create a personalized action plan. You'll also be able to track your progress in real time. Learn more at **ahealthyme.com**.

Fitness and Weight-Loss Reimbursements

Interested in a healthier lifestyle? You may have access to reimbursements for participating in a qualified fitness or weight-loss program. For more information, check your benefit material, log in at **bluecrossma.com/myblue**, or call Member Service at the number on your ID card.

Telehealth—Real-Time Video Visits

Do you need care that is convenient and easy to access wherever you are? With Telehealth, you can have real-time video visits with a doctor or therapist using your computer, smartphone, or tablet. Telehealth can be a quality alternative to face-to-face doctor visits, and could help avoid costly emergency room trips for simple conditions. To see if you have coverage for Telehealth, please refer to your plan benefits or visit **bluecrossma.com/telehealth** to learn more.

MyBlue Member App

Get instant, secure access to your health care information from the convenience of your mobile device

- Access an interactive ID card, and email a copy to your doctor
- Direct dial important phone numbers like Member Service
- Review recent claims, prescriptions, and doctor visits
- Find nearby doctors, dentists, and hospitals
- View information for dependents under 18

Download the app from the **App Store®** or **Google Play™.**

Go Digital

Whenever, wherever, it's easy to stay in touch with Blue Cross. Get the information and resources you need to keep up with important health topics, understand your benefits—and live a happier, healthier life. Connect with us on Facebook or Twitter—or sign up for email by going to **bluecrossma.com/email**.

Get the Most from Your Plan

Blue365®
Because health is a big deal

Blue365 offers exclusive health and wellness deals, keeping you healthy and happy, every day of the year. From gym memberships and diet programs to family activities, we have just the deal for you. To see all that Blue365 has to offer, go to **blue365deals.com**.

Living Healthy Babies®—From Preconception Through Your Baby's First Year

Have questions about pregnancy, labor, and what to expect during your baby's first year? We can help answer your questions. Visit **livinghealthybabies.com** today.

Stay Connected with the Blue Cross MA Message Wire

Blue Cross MA Message Wire is a new communication channel that sends important information—like wellness tips, screening reminders, member discounts, and plan information—straight to your phone. Sign-up is quick and easy. Text **bluecrossma** to **73529**, or call **1-844-779-8813**. Make sure to have your Blue Cross Member ID card ready.

For More Information

Online Tutorials

View our engaging online tutorials to quickly and easily understand how your plan works at **bluecrossma.com/tutorial**.

Member Service (See front of your ID card for phone number)

For general questions about your coverage, call Member Service, Monday through Friday, 8:00 a.m. to 6:00 p.m. E.T. TTY: **711**. Twitter: **@BCBSMAservice**

Find a Doctor & Estimate Costs

Our Find a Doctor & Estimate Costs tool makes it easy for you to find what you need.

- Search for doctors, dentists, hospitals, and other health care providers
- Get cost estimates for over 1,600 procedures
- Read and write reviews
- Compare up to ten doctors at a time
- And more

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For questions about out-of-country provider access and services, call **1-800-810-BLUE (2583)**.

Blue Care® Line 1-888-247-BLUE (2583)

Use this number for questions about your health if you're hurt or sick and not sure where to get care. Call us 24/7 to speak directly to a registered nurse who can help guide your care.

Lost Member ID Card 1-800-253-5210

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If you have prescription drug coverage, call **1-800-892-5119** anytime, 24 hours a day, 7 days a week, to learn more.

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MASSACHUSETTS

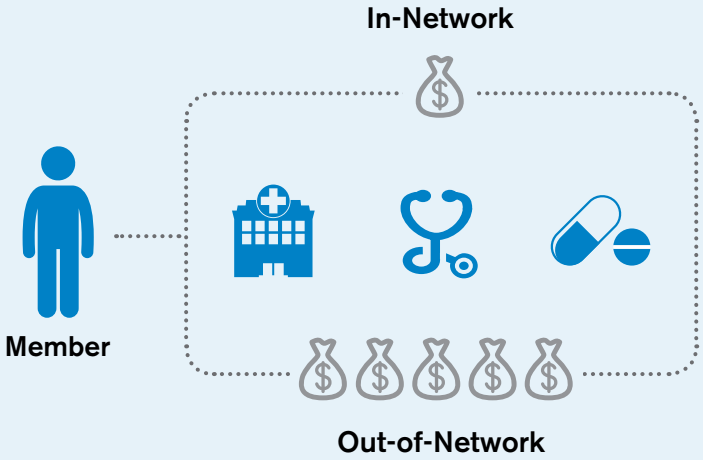
Quick Start Guide

PPO

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

PPO: Preferred Provider Organization

- Greater flexibility than an HMO
- You have a network of doctors to choose from, but you don't need to name one doctor as your primary care provider (PCP)
- If you use doctors and hospitals from outside of your PPO network, it may cost more
- You don't need a referral from your PCP to see a specialist
- **Your out-of-pocket health care costs may be higher**
- Some plans have deductibles before benefits are paid, and the amount varies between plans



Your Choice

Your health care plan is a preferred provider organization plan. With this plan, you have the option of selecting in-network (preferred) or out-of-network (non-preferred) providers. The choice is always yours to make, **but you may be responsible for much higher out-of-pocket costs when you seek care out of network**.

Know How to Get the Highest Coverage

You receive the highest level of benefits (that is, in-network benefits) when you choose preferred providers. Before you receive care, check to see if the health care provider or facility you chose or were referred to is part of the local Blue Cross plan's PPO network.

How to Find a Preferred Provider

To find a preferred provider, you can:

- Visit our website at **bluecrossma.com/findadoctor**
- Call our Physician Selection Service at **1-800-821-1388** and request a provider directory

To Find Providers

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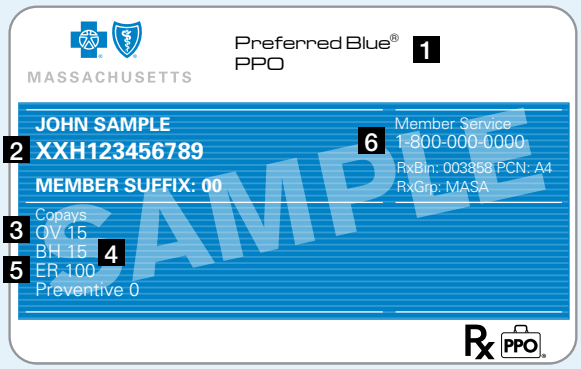

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Mail Service Pharmacy 1-800-892-5119

If you have prescription drug coverage, call **1-800-892-5119** anytime, 24 hours a day, 7 days a week, to learn more.

MASSACHUSETTS

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Your Mail Service
Pharmacy Benefit

As a member of Blue Cross Blue Shield of Massachusetts, you can buy certain medications at the Express Scripts mail service pharmacy.

It's a great way to save by purchasing prescriptions on a long-term basis.

Check Out These Benefits!

Savings: The biggest advantage of the mail service pharmacy is that for most long-term maintenance medications you can order up to a 90-day supply. Often times, using mail service results in the lowest possible out-of-pocket costs to you as a member.

Convenience: Your medications will be delivered to your home, postage paid, within 14 days of mailing your new prescription.

Confidentiality: If you have questions, you can call Express Scripts toll-free, 24 hours a day. Registered pharmacists are available to answer your questions about your prescriptions confidentially. Call **1-800-892-5119.**

Special-Needs Services Available: For the convenience of our hearing-impaired members, Express Scripts is TTY-ready, and has installed a separate toll-free number for you to use with your TTY equipment. The number is **1-800-305-5376.**

For our vision-impaired members, upon special request with your order, Express Scripts can provide Braille labels for your medication.

And for our non-English-speaking members, Express Scripts can provide translation services when you call the toll-free line.

Refer to your benefit literature for specific coverage information.

Three Easy Steps To Use Mail Service

For long-term prescriptions, use our mail service pharmacy to save.

1. Ask your doctor to prescribe medications for up to a 90-day supply, plus refills when applicable. (If you're already taking medication on a long-term basis, ask your doctor for a new prescription.)
2. Complete the attached Mail Order Form for each member submitting a prescription. Be sure to answer all of the questions.
3. Seal the form, prescriptions, and the appropriate copayment in the pocket in this brochure (do not send cash). Then simply mail it in. Be sure to write your ID number exactly as it appears on your ID card.

Your order will be quickly processed and sent to you by mail or UPS. Allow 14 days for delivery from the date you mail the order. To prevent delays, do not fill medications that are needed quickly or short-term medications (e.g. antibiotics) via mail service.

Confidential Subscriber/Patient Profile

Please write your ID number, name, and address on the attached form. Then complete the Patient Profile for you and each of your dependents submitting prescriptions, indicating any drug allergies, and health conditions. Express Scripts will use this information to check any potential drug interactions when you have prescriptions filled. If there are no drug allergies, please check "None" in the box provided.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Instructions

New Prescriptions:

- Have your doctor/provider write the prescription for up to a 90-day supply
- To prevent any delays, make sure that an approved formulary exception (if applicable) for any medications that are non-covered or require prior authorization is on file before you place your order
- Complete all information requested on the attached Mail Order Form
- Select your preference for Safety Caps in the appropriate box
- Ensure that the patient's full name, age, ID number, and address appear on each prescription
- Find out the appropriate copayment necessary for the medication prescribed
- Place prescriptions and copayments in return envelope and mail

Refills:

- Call **1-800-892-5119** or visit **www.express-scripts.com** to refill your order, or
- Place refill slips and copayments in the return envelope and mail it

Make all checks or money orders payable to "Express Scripts". Do not send cash. If paying by credit card, complete the information under "Credit Card Information."

What Do I Do in Emergency Situations?

When you need medication immediately, simply have your prescription filled at a local pharmacy. If you need medication immediately, but will be taking it on an ongoing basis, you can ask your doctor to write two prescriptions:

- You can fill the first prescription at a local participating pharmacy;
- Send the second prescription (up to a 90-day supply), along with your copayment, to Express Scripts immediately.

About Your Prescription

Blue Cross Blue Shield of Massachusetts maintains a list of covered prescription drugs. If you have any questions about whether or not your medications are covered, or subject to Quality Care Dosing, Step Therapy, or Prior Authorization, please visit **www.bluecrossma.com/pharmacy** or call Blue Cross Blue Shield of Massachusetts Member Service at the number on the front of your ID card.

Mail Service Questions

Call Express Scripts customer service 24 hours a day, 7 days a week. Pharmacy consultation is also available around-the-clock.
Toll-free number: **1-800-892-5119** (TTY: **1-800-305-5376**)

Answers to Your Questions

How Do I Determine What Copayment Amount? I Should Include With My Order?

Check your benefit literature, and if you still have specific questions, call the Blue Cross Blue Shield of Massachusetts Member Service phone number listed on the front of your ID card.

Why Did My Order Contain Generic Drugs? When My Prescription Requested a Brand-Name Version?

When authorized by your doctor and permitted by applicable law, Express Scripts will dispense a generic drug. This usually saves you money, so whenever possible, ask your doctor to prescribe generic drugs.

Why Isn't My Drug Available Through the ESI Mail Service?

Certain medications that require immediate administration or are used for short periods of time are inappropriate for mail service. In addition, for certain medications classified as specialty drugs, Blue Cross Blue Shield of Massachusetts has established a relationship with a preferred specialty pharmacy. They offer additional services that are not offered by our mail service pharmacy.

How Do I Order Refills?

Simply call the toll-free number, **1-800-892-5119**, and order your refills over the phone. You can also visit the Express Scripts website to refill your order **(www.express-scripts.com)**. Once you have ordered through mail service, you will receive a refill slip with your prescription.

Enclose the slip and the appropriate copayment amount in the order envelope (which is provided).

Please Note:

Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions regarding your medication, please call Express Scripts customer service at **1-800-892-5119**.

It's the patient's responsibility to report to Express Scripts any changes in drug allergies, health conditions, chronic diseases, and drug sensitivities.

Prescription information about members and dependents is used by Express Scripts to administer your prescription program. As part of the administration, Express Scripts reports that information to Blue Cross Blue Shield of Massachusetts. Express Scripts also uses the information and prescription data gathered from claims submitted nationwide for reporting and analysis, without identifying individual patients in accordance with applicable laws.

MASSACHUSETTS

Express Scripts, an independent company, administers your prescription benefit and its services are being provided on behalf of Blue Cross Blue Shield of Massachusetts. ® Registered Marks of the Blue Cross and Blue Shield Association.

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147610M 32-7040

Express Scripts Pharmacy Prescription Order Form

To order online: sign in at www.StartHomeDelivery.com and follow the prompts.

To order by mail: complete this form and ask your doctor to write your prescription for a 90-day supply or the maximum days supply allowed by your plan.

- Use ALL CAPITAL LETTERS in BLACK INK. Fill in the ovals as shown (●).
- Remember to mail your prescription with this completed form. Your medication will arrive within two weeks from the date we receive your first order.

NOTE: Standard shipping is FREE for online and mail orders.

1041

Detach Here

For all orders after 08/01/2011, use this form.
Fold and tear off this piece before putting in the return envelope.

PATIENT 1 (CARDHOLDER)

ID Card Number

First Name | MI | Date of Birth (MM/DD/YYYY)

Last Name | Gender ○ M ○ F

Some medications cannot be delivered to a PO Box. Provide a street address to allow delivery of your order.

Shipping Address 1

Shipping Address 2

City | State

Zip Code

○ Check here for rush shipment. Your order, once received and filled, will be shipped overnight for $21.

Email

Please select one as your preferred telephone number

○ Daytime Phone ( ) —

○ Evening Phone ( ) —

○ Cell Phone ( ) —

Doctor/Prescriber Last Name | Doctor/Prescriber Phone Number ( ) —

PATIENT 2

First Name | MI | Date of Birth (MM/DD/YYYY)

Last Name | Gender ○ M ○ F

Email

Doctor/Prescriber Last Name | Doctor/Prescriber Phone Number ( ) —

PAYMENT

All individuals included in the family will be charged to this credit card.

○ Apply to this order only ○ Apply to all orders

Amount Enclosed $.

○ Check Card ○ Credit Card ○ Check / Money Order

Card # | Exp. Date (MM/YY)

Sign here to authorize card payment X

Detach Here

REMINDER: This section must be removed before mailing.

1042

Patient 1 (Cardholder)		Patient 2
Name: _____ I want non-child resistant caps, when available. Date of Birth (MM/DD/YYYY) / /	**Date of Birth is required for patient identification.** Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.	Name: _____ I want non-child resistant caps, when available. Date of Birth (MM/DD/YYYY) / /
DRUG ALLERGIES List other Allergies here:	**No Known Allergies** Acetaminophen/Tylenol® Amoxicillin Aspirin Cephalosporin (i.e., Keflex®, Cephalexin) Codeine Erythromycin, Biaxin®, Zithromax® NSAIDs (i.e., Ibuprofen, Naproxen) Oxycodone (i.e., OxyContin®, Percocet®) Penicillin Sulfa Tetracycline (i.e., Doxycycline, Minocycline)	List other Allergies here:
HEALTH CONDITIONS List other Health Conditions here:	**No Known Health Conditions** Arthritis (715.9) Asthma (493.9) Chronic Bronchitis or Emphysema (496) Depression (311) Diabetes Type I (250.01) Diabetes Type II (250.00) Epilepsy/Seizures (345.9) GERD (530.81) Glaucoma (365.9) High Cholesterol (272.9) Hormone Replacement Therapy (627.9) Hypertension (401.9) Thyroid: Low (244.9)	List other Health Conditions here:
OTC List other OTC that you take on a regular basis:	**No Over-the-Counter Medications** Acetaminophen/Tylenol® Advil®/Aleve®/Motrin® Aspirin/Excedrin®	List other OTC that you take on a regular basis:
DEVICES List Medical Devices here:	**No Medical Devices** Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	List Medical Devices here:
OTHER List other Prescription Medications here:	**No Other Prescriptions** Prescription Medications not filled through Express Scripts Pharmacy.	List other Prescription Medications here:

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required X _____

More than two family members on your plan? On a separate sheet of paper, write the family member(s) name, date of birth, allergies and health conditions along with the name and phone number of their doctor/prescriber.

Please Note: Your order may be filled at any one of our Express Scripts Pharmacies located nationwide.

MLR- DRAFTONLY (MAILER) REV 07/27/2011

Pref Pref Pref

Please note

Please note that all prescriptions requiring a formulary exception will not be processed without prior approval. To prevent any delays, make sure that an approved formulary exception (if applicable) is on file before you place your order.

Thank you for using our mail service prescription drug program.

Fold Fold Fold

MLRBENP

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 3580 ST LOUIS MO
POSTAGE WILL BE PAID BY ADDRESSEE

EXPRESS SCRIPTS®
Home Delivery Service
PO Box 66566
St Louis, MO 63166-9967

Did You Remember To...

- Complete all applicable information
- Include your ID number on the mail order form
- Enclose the original prescription, mail order form, and appropriate copayment
- Make checks or money orders payable to "Express Scripts", or include credit card information

Detach envelope to mail presciption order form

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Pref Pref Pref

Detach envelope to mail presciption order form

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Glue

inside envelope

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$9 Generic Medications List

Blue Cross Blue Shield of Massachusetts offers our members 90-day supplies of certain generic medications for just $9 when the prescription is filled through the Express Scripts Mail Service Pharmacy. The following list includes those medications that are available for $9. Normal prescription guidelines apply, which in some cases results in prescription supplies for fewer than 90 days. This list is up-to-date as of January 2017. You can find the latest information about your medications by visiting **bluecrossma.com/medications**.

If your copayment for a 90-day supply through the mail pharmacy is less than $9, you will pay the lesser amount. $9 price is based only on quantities stated below. The price of the medication may differ if the quantity purchased is different. The $9 price is subject to change, so you should always confirm your cost prior to filling a prescription.

To price drugs, log in to MyBlue at **bluecrossma.com/myblue** and select Review My Pharmacy Benefits under the Manage Your Plan section. Next, click the Express Scripts Account link.

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
ANESTHETICS			
LIDOCAINE HCL	20MG/ML	SOLUTION	300
ANTIARTHRITICS			
ALLOPURINOL	100MG	TABLET	90
ALLOPURINOL	300MG	TABLET	90
MELOXICAM	7.5MG	TABLET	90
MELOXICAM	15MG	TABLET	90
INDOMETHACIN	25MG	CAPSULE	180
IBUPROFEN	400MG	TABLET	270
IBUPROFEN	600MG	TABLET	180
IBUPROFEN	800MG	TABLET	180
NAPROXEN	250MG	TABLET	180
NAPROXEN	375MG	TABLET	180
NAPROXEN	500MG	TABLET	180
DICLOFENAC SODIUM	50MG	TABLET DR	180
DICLOFENAC SODIUM	75MG	TABLET DR	180
NAPROXEN SODIUM	275MG	TABLET	180
NAPROXEN SODIUM	220MG	TABLET	180
ANTIASTHMATICS			
ALBUTEROL SULFATE	2MG/5ML	SYRUP	1440
ALBUTEROL SULFATE	0.83MG/ML	SOLUTION	225
IPRATROPIUM BROMIDE	0.2MG/ML	SOLUTION	225

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DRUG NAME	STRENGTH	FORM	$9 QUANTITY
ANTIBIOTICS			
NEO/POLYMYX B SULF/ DEXAMETH	3.5-10K-.1	OINT.(GM)	4
POLYMYXIN B SULFATE/TMP	10K U-0.1%	DROPS	30
SULFACETAMIDE SODIUM	0.1	DROPS	15
ERYTHROMYCIN BASE	5MG/G	OINT.(GM)	4
GENTAMICIN SULFATE	0.003	DROPS	15
PENICILLIN V POTASSIUM	250MG/5ML	SUSP RECON	300
PENICILLIN V POTASSIUM	250MG/5ML	SUSP RECON	300
PENICILLIN V POTASSIUM	250MG	TABLET	84
AMOXICILLIN TRIHYDRATE	250MG	CAPSULE	90
AMOXICILLIN TRIHYDRATE	500MG	CAPSULE	90
AMOXICILLIN TRIHYDRATE	125MG/5ML	SUSP RECON	240
AMOXICILLIN TRIHYDRATE	250MG/5ML	SUSP RECON	300
AMOXICILLIN TRIHYDRATE	250MG/5ML	SUSP RECON	300
AMOXICILLIN TRIHYDRATE	250MG/5ML	SUSP RECON	300
CEPHALEXIN MONOHYDRATE	250MG	CAPSULE	84
CEPHALEXIN MONOHYDRATE	500MG	CAPSULE	90
ISONIAZID	300MG	TABLET	90
METRONIDAZOLE	250MG	TABLET	84
METRONIDAZOLE	500MG	TABLET	42
CIPROFLOXACIN HCL	250MG	TABLET	42
CIPROFLOXACIN HCL	500MG	TABLET	60
AMOXICILLIN	500 MG	TABLET	90
SULFAMETHOXAZOLE/ TRIMETHOPRIM	400-80MG	TABLET	84
SULFAMETHOXAZOLE/ TRIMETHOPRIM	800-160MG	TABLET	60
AMOXICILLIN TRIHYDRATE	400MG/5ML	SUSP RECON	150
AMOXICILLIN TRIHYDRATE	200MG/5ML	SUSP RECON	150
ANTICOAGULANTS			
WARFARIN SODIUM	10MG	TABLET	90
WARFARIN SODIUM	2MG	TABLET	90
WARFARIN SODIUM	1MG	TABLET	90
WARFARIN SODIUM	5MG	TABLET	90
WARFARIN SODIUM	2.5MG	TABLET	90
WARFARIN SODIUM	7.5MG	TABLET	90
WARFARIN SODIUM	3MG	TABLET	90
WARFARIN SODIUM	4MG	TABLET	90
WARFARIN SODIUM	6MG	TABLET	90

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
ANTIFUNGALS			
FLUCONAZOLE	150MG	TABLET	3
TERBINAFINE	250MG	TABLET	90
ANTIHISTAMINES			
HYDROXYZINE PAMOATE	25MG	CAPSULE	90
PROMETHAZINE HCL	6.25MG/5ML	SYRUP	540
PROMETHAZINE HCL	12.5MG	TABLET	90
PROMETHAZINE HCL	25MG	TABLET	90
PROMETHAZINE HCL	50MG	TABLET	90
ANTIHYPERGLYCEMICS			
GLYBURIDE	1.25MG	TABLET	90
GLYBURIDE	2.5MG	TABLET	90
GLYBURIDE	5MG	TABLET	90
GLYBURIDE,MICRONIZED	1.5MG	TABLET	90
GLYBURIDE,MICRONIZED	3MG	TABLET	90
GLYBURIDE,MICRONIZED	6MG	TABLET	90
GLIMEPIRIDE	1MG	TABLET	90
GLIMEPIRIDE	2MG	TABLET	90
GLIMEPIRIDE	4MG	TABLET	90
METFORMIN HCL	500MG	TABLET	180
METFORMIN HCL	850MG	TABLET	180
GLIPIZIDE	5MG	TABLET	90
GLIPIZIDE	10MG	TABLET	180
GLIPIZIDE	5MG	TAB OSM 24	90
METFORMIN HCL	1000MG	TABLET	180
METFORMIN HCL	500MG	TAB.SR 24H	180
GLYBURIDE/METFORMIN HCL	5MG-500MG	TABLET	180
ANTINEOPLASTICS			
MEGESTROL ACETATE	20MG	TABLET	180
ANTIPARKINSON DRUGS			
TRIHEXYPHENIDYL HCL	2MG	TABLET	180
BENZTROPINE MESYLATE	0.5MG	TABLET	180
BENZTROPINE MESYLATE	1MG	TABLET	90
BENZTROPINE MESYLATE	2MG	TABLET	90
ANTIVIRALS			
ACYCLOVIR	200MG	CAPSULE	90

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
CARDIAC DRUGS			
ISOSORBIDE MONONITRATE	10MG	TABLET	180
DILTIAZEM HCL	120MG	CAP.SR 24H	90
VERAPAMIL HCL	120MG	TABLET	180
VERAPAMIL HCL	80MG	TABLET	180
DILTIAZEM HCL	30MG	TABLET	180
DILTIAZEM HCL	60MG	TABLET	180
AMIODARONE HCL	200MG	TABLET	90
VERAPAMIL HCL	240MG	TABLET SA	90
VERAPAMIL HCL	180MG	TABLET SA	90
VERAPAMIL HCL	120MG	TABLET SA	180
ISOSORBIDE MONONITRATE	60MG	TAB.SR 24H	90
ISOSORBIDE MONONITRATE	30MG	TAB.SR 24H	90
CARDIOVASCULAR			
ENALAPRIL MALEATE	5MG	TABLET	90
ENALAPRIL MALEATE	10MG	TABLET	90
ENALAPRIL MALEATE	20MG	TABLET	90
ENALAPRIL MALEATE	2.5MG	TABLET	90
HYDRALAZINE HCL	10MG	TABLET	180
HYDRALAZINE HCL	100MG	TABLET	270
HYDRALAZINE HCL	25MG	TABLET	90
HYDRALAZINE HCL	50MG	TABLET	270
PRAZOSIN HCL	1MG	CAPSULE	90
CLONIDINE HCL	0.1MG	TABLET	180
CLONIDINE HCL	0.2MG	TABLET	180
CLONIDINE HCL	0.3MG	TABLET	90
METHYLDOPA	250MG	TABLET	180
METHYLDOPA	500MG	TABLET	180
CARVEDILOL	25MG	TABLET	180
CARVEDILOL	12.5MG	TABLET	180
CARVEDILOL	3.125MG	TABLET	180
CARVEDILOL	6.25MG	TABLET	180
LABETALOL HCL	300MG	TABLET	180
LABETALOL HCL	200MG	TABLET	180
LABETALOL HCL	100MG	TABLET	180
METOPROLOL TARTRATE	25MG	TABLET	180
PROPRANOLOL HCL	10MG	TABLET	180
METOPROLOL TARTRATE	100MG	TABLET	180

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
METOPROLOL TARTRATE	50MG	TABLET	180
ATENOLOL	100MG	TABLET	90
ATENOLOL	50MG	TABLET	90
ATENOLOL	25MG	TABLET	90
QUINAPRIL HCL	10MG	TABLET	90
QUINAPRIL HCL	20MG	TABLET	90
QUINAPRIL HCL	5MG	TABLET	90
QUINAPRIL HCL	40MG	TABLET	90
GUANFACINE HCL	1MG	TABLET	90
GUANFACINE HCL	2MG	TABLET	90
BENAZEPRIL/ HYDROCHLOROTHIAZIDE	5-6.25MG	TABLET	90
BENAZEPRIL/ HYDROCHLOROTHIAZIDE	10-12.5MG	TABLET	90
BENAZEPRIL/ HYDROCHLOROTHIAZIDE	20-12.5MG	TABLET	90
BENAZEPRIL/ HYDROCHLOROTHIAZIDE	20-25MG	TABLET	90
DOXAZOSIN MESYLATE	1MG	TABLET	90
DOXAZOSIN MESYLATE	2MG	TABLET	90
DOXAZOSIN MESYLATE	4MG	TABLET	90
DOXAZOSIN MESYLATE	8MG	TABLET	90
SOTALOL HCL	80MG	TABLET	90
SOTALOL HCL	240MG	TABLET	180
BISOPROL/ HYDROCHLOROTHIAZIDE	2.5-6.25MG	TABLET	90
BISOPROL/ HYDROCHLOROTHIAZIDE	5-6.25MG	TABLET	90
BISOPROL/ HYDROCHLOROTHIAZIDE	10-6.25MG	TABLET	90
LOVASTATIN	20MG	TABLET	90
LOVASTATIN	40MG	TABLET	90
LOVASTATIN	10MG	TABLET	90
TERAZOSIN HCL	1MG	CAPSULE	90
TERAZOSIN HCL	2MG	CAPSULE	90
TERAZOSIN HCL	5MG	CAPSULE	90
TERAZOSIN HCL	10MG	CAPSULE	90
LISINOPRIL	5MG	TABLET	90
LISINOPRIL	10MG	TABLET	90
LISINOPRIL	20MG	TABLET	90

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
LISINOPRIL	40MG	TABLET	90
LISINOPRIL	2.5MG	TABLET	90
LISINOPRIL	30MG	TABLET	90
RAMIPRIL	1.25MG	CAPSULE	90
RAMIPRIL	2.5MG	CAPSULE	90
RAMIPRIL	5MG	CAPSULE	90
RAMIPRIL	10MG	CAPSULE	90
BENAZEPRIL HCL	5MG	TABLET	90
BENAZEPRIL HCL	10MG	TABLET	90
BENAZEPRIL HCL	20MG	TABLET	90
BENAZEPRIL HCL	40MG	TABLET	90
PRAVASTATIN SODIUM	10MG	TABLET	90
PRAVASTATIN SODIUM	20MG	TABLET	90
PRAVASTATIN SODIUM	40MG	TABLET	90
ENALAPRIL/ HYDROCHLOROTHIAZIDE	5-12.5MG	TABLET	90
BISOPROLOL FUMARATE	10MG	TABLET	90
BISOPROLOL FUMARATE	5MG	TABLET	90
ATENOLOL/CHLORTHALIDONE	50MG-25MG	TABLET	90
ATENOLOL/CHLORTHALIDONE	100-25MG	TABLET	90
LISINOPRIL/ HYDROCHLOROTHIAZIDE	20-12.5MG	TABLET	90
LISINOPRIL/ HYDROCHLOROTHIAZIDE	20-25MG	TABLET	90
LISINOPRIL/ HYDROCHLOROTHIAZIDE	10-12.5MG	TABLET	90
CNS DRUGS			
PRIMIDONE	250MG	TABLET	180
PRIMIDONE	50MG	TABLET	180
CONTRACEPTIVES			
NORGESTIMATE-ETHINYL ESTRADIOL	7DAYSX3 28	TABLET	84
LEVONORGESTREL-ETH ESTRA	0.15-0.03	TABLET	84
COUGH/COLD PREPARATIONS			
D-METHORPHAN HB/ PROMETH HCL	15-6.25/5	SYRUP	360
BENZONATATE	100MG	CAPSULE	42

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
DIURETICS			
INDAPAMIDE	2.5MG	TABLET	90
INDAPAMIDE	1.25MG	TABLET	90
TORSEMIDE	5MG	TABLET	90
TORSEMIDE	10MG	TABLET	90
TORSEMIDE	20MG	TABLET	90
TORSEMIDE	100MG	TABLET	90
SPIRONOLACTONE	25MG	TABLET	90
CHLOROTHIAZIDE	250 MG	TABLET	90
HYDROCHLOROTHIAZIDE	12.5MG	CAPSULE	90
HYDROCHLOROTHIAZIDE	25MG	TABLET	90
HYDROCHLOROTHIAZIDE	50MG	TABLET	90
FUROSEMIDE	20MG	TABLET	90
FUROSEMIDE	40MG	TABLET	90
FUROSEMIDE	80MG	TABLET	90
AMILORIDE/ HYDROCHLOROTHIAZIDE	5MG-50MG	TABLET	90
TRIAMTERENE/ HYDROCHLOROTHIAZID	37.5-25MG	CAPSULE	90
TRIAMTERENE/ HYDROCHLOROTHIAZID	75-50MG	TABLET	90
TRIAMTERENE/ HYDROCHLOROTHIAZID	37.5-25MG	TABLET	90
EENT PREPS			
TIMOLOL MALEATE	0.0025	DROPS	15
TIMOLOL MALEATE	0.0025	DROPS	15
TIMOLOL MALEATE	0.0025	DROPS	15
TIMOLOL MALEATE	0.005	DROPS	15
TIMOLOL MALEATE	0.005	DROPS	15
TIMOLOL MALEATE	0.005	DROPS	15
LEVOBUNOLOL HCL	0.005	DROPS	15
LEVOBUNOLOL HCL	0.005	DROPS	15
LEVOBUNOLOL HCL	0.005	DROPS	15
ELECT/CALORIC/H2O			
POTASSIUM CHLORIDE	10MEQ	TAB PRT SR	90

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
GASTROINTESTINAL			
METOCLOPRAMIDE HCL	5MG/5ML	SOLUTION	180
LACTULOSE	10G/15ML	SOLUTION	960
RANITIDINE HCL	300MG	TABLET	90
PROCHLORPERAZINE MALEATE	10MG	TABLET	90
MECLIZINE HCL	12.5MG	TABLET	180
DICYCLOMINE HCL	10MG	CAPSULE	270
DICYCLOMINE HCL	20MG	TABLET	180
METOCLOPRAMIDE HCL	10MG	TABLET	180
METOCLOPRAMIDE HCL	5MG	TABLET	180
FAMOTIDINE	40MG	TABLET	90
HORMONES			
ESTRADIOL	1MG	TABLET	90
ESTRADIOL	2MG	TABLET	90
ESTRADIOL	0.5MG	TABLET	90
MEDROXYPROGESTERONE ACET	10MG	TABLET	42
MEDROXYPROGESTERONE ACET	2.5MG	TABLET	90
MEDROXYPROGESTERONE ACET	5MG	TABLET	90
PREDNISONE	1MG	TABLET	90
PREDNISONE	10MG	TABLET	90
PREDNISONE	2.5MG	TABLET	90
PREDNISONE	20MG	TABLET	90
PREDNISONE	5MG	TABLET	90
DEXAMETHASONE	0.5MG	TABLET	90
DEXAMETHASONE	0.75MG	TABLET	90
DEXAMETHASONE	4MG	TABLET	18
METHYLPREDNISOLONE	4MG	TAB DS PK	63
MUSCLE RELAXANTS			
CYCLOBENZAPRINE HCL	5MG	TABLET	90
TIZANIDINE HCL	2MG	TABLET	180
TIZANIDINE HCL	4MG	TABLET	180
ORPHENADRINE CITRATE	100MG	TABLET SA	90
BACLOFEN	10MG	TABLET	180
CYCLOBENZAPRINE HCL	10MG	TABLET	90

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
PSYCHOTHERAPEUTIC DRUGS			
CLORAZEPATE DIPOTASSIUM	15MG	TABLET	90
CLORAZEPATE DIPOTASSIUM	3.75MG	TABLET	180
CLORAZEPATE DIPOTASSIUM	7.5MG	TABLET	90
FLUPHENAZINE HCL	1MG	TABLET	180
FLUPHENAZINE HCL	10MG	TABLET	90
FLUPHENAZINE HCL	2.5MG	TABLET	90
TRIFLUOPERAZINE HCL	1MG	TABLET	90
TRIFLUOPERAZINE HCL	10MG	TABLET	90
TRIFLUOPERAZINE HCL	2MG	TABLET	90
TRIFLUOPERAZINE HCL	5MG	TABLET	90
THIORIDAZINE HCL	25MG	TABLET	180
THIORIDAZINE HCL	50MG	TABLET	90
HALOPERIDOL	0.5MG	TABLET	90
HALOPERIDOL	1MG	TABLET	90
HALOPERIDOL	2MG	TABLET	90
HALOPERIDOL	5MG	TABLET	90
LITHIUM CARBONATE	300MG	CAPSULE	270
CITALOPRAM HYDROBROMIDE	20MG	TABLET	90
CITALOPRAM HYDROBROMIDE	40MG	TABLET	90
CITALOPRAM HYDROBROMIDE	10MG	TABLET	90
FLUOXETINE HCL	10MG	CAPSULE	90
FLUOXETINE HCL	20MG	CAPSULE	90
FLUOXETINE HCL	40MG	CAPSULE	90
PAROXETINE HCL	10MG	TABLET	90
PAROXETINE HCL	20MG	TABLET	90
PAROXETINE HCL	30MG	TABLET	90
PAROXETINE HCL	40MG	TABLET	90
SERTRALINE HCL	25MG	TABLET	90
TRAZODONE HCL	50MG	TABLET	90
TRAZODONE HCL	100MG	TABLET	90
TRAZODONE HCL	150MG	TABLET	90
NORTRIPTYLINE HCL	10MG	CAPSULE	90
NORTRIPTYLINE HCL	25MG	CAPSULE	90
IMIPRAMINE HCL	10MG	TABLET	90
IMIPRAMINE HCL	25MG	TABLET	90
IMIPRAMINE HCL	50MG	TABLET	90
DOXEPIN HCL	10MG	CAPSULE	90
DOXEPIN HCL	25MG	CAPSULE	90

DRUG NAME	STRENGTH	FORM	$9 QUANTITY
MIRTAZAPINE	15MG	TABLET	90
MIRTAZAPINE	30MG	TABLET	90
MIRTAZAPINE	45MG	TABLET	90
BUSPIRONE HCL	5MG	TABLET	180
BUSPIRONE HCL	10MG	TABLET	180
BUSPIRONE HCL	15MG	TABLET	180
SEDATIVE/HYPNOTICS			
FLURAZEPAM HCL	15MG	CAPSULE	90
SKIN PREPS			
HYDROCORTISONE	0.01	CREAM(GM)	90
HYDROCORTISONE	0.025	CREAM(GM)	90
TRIAMCINOLONE ACETONIDE	0.005	CREAM(GM)	45
THYROID PREPS			
LEVOTHYROXINE SODIUM	112MCG	TABLET	90
LEVOTHYROXINE SODIUM	25MCG	TABLET	90
LEVOTHYROXINE SODIUM	50MCG	TABLET	90
LEVOTHYROXINE SODIUM	100MCG	TABLET	90
LEVOTHYROXINE SODIUM	75MCG	TABLET	90
LEVOTHYROXINE SODIUM	200MCG	TABLET	90
LEVOTHYROXINE SODIUM	125MCG	TABLET	90
LEVOTHYROXINE SODIUM	150MCG	TABLET	90
LEVOTHYROXINE SODIUM	175MCG	TABLET	90
LEVOTHYROXINE SODIUM	88MCG	TABLET	90
LEVOTHYROXINE SODIUM	137MCG	TABLET	90
UNCLASSIFIED DRUG PRODUCTS			
ALENDRONATE SODIUM	35MG	TABLET	12
OXYBUTYNIN CHLORIDE	5MG	TABLET	180
ALENDRONATE SODIUM	10MG	TABLET	90
ALENDRONATE SODIUM	5MG	TABLET	90
CHLORHEXIDINE GLUCONATE	0.0012	MOUTHWASH	1419
ALENDRONATE SODIUM	70MG	TABLET	12
VITAMINS			
FOLIC ACID	1MG	TABLET	90

1. The $9 or less price applies to a 90-day supply of each generic drug. Cost may vary based on prescription quantity or day supply. A processing fee may apply. The coverage and prices of certain medications are also subject to the specific terms of your plan. In applicable states, sales tax may be added to the cost of your prescriptions. Medications and pricing are subject to change without notice. Drug list is valid until Dec. 31, 2017. Changes are made available to your Plan Sponsor. Pre-packaged drugs are only available for $9 in the package sizes specified on the list. Cost of standard shipping is included as part of your prescription benefit plan.

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You have options

Quicker, Less Expensive Alternatives to the ER

You should always go to the nearest emergency room in a life-threatening situation. But in other cases, even for urgent injuries, you have other options that can save you time and money.

First, Talk to Your Primary Care Provider

Unless it's a true emergency, it's always best to call your doctor's office first, even after hours. He or she may want to see you or suggest alternatives to the emergency room. If the doctor's office is closed, there may be recorded after-hours care instructions or the option to speak with an on-call nurse or doctor who can provide advice based upon your medical history. After you call your doctor, in the absence of severe symptoms, consider the options below:

Option	What It Is	What They Can Help You With	Hours	Relative Cost	How to Find One
Blue Care Line℠	Speak with a nurse by phone. Explain your symptoms, and the nurse will help you decide what to do next.	Assessment for the treatment of: • Fever • Dizziness • Cuts • General discomfort	24/7	No cost	Call the Blue Care Line at **1-888-247-BLUE (2583)**
Telehealth	Real-time video visits with a doctor, when you have common conditions and it's difficult to get to the doctor's office.	• Back pain • Bronchitis • Cough • Diarrhea • Fever • Rashes • Respiratory infections • Sinus infections • Sore throat • Skin conditions • Urinary tract infections Plus, some symptoms treated at limited service clinics and some symptoms treated at urgent care centers	24/7 for medical care	$$	Visit **bluecrossma.com/telehealth** to learn more.
Limited Services Clinics[1]	Clinics located within your local pharmacy that treat simple medical concerns that don't need the emergency room.	• Colds & flu • Contraceptive care • Earache • Diarrhea • Gout • Headache • Heartburn • Indigestion • Joint pain • Nausea • Pinkeye • Sore throat • Strains & sprains • Yeast infection • Vomiting	Days, evenings, weekends	$$	In Massachusetts: Go to **bluecrossma.com/findadoctor** • Select Medical Facility • Click on the Specialty tab • Select Clinics, Limited Services or Urgent Care Center • Outside of Massachusetts: Members can either: » Type the name of the urgent care center or limited clinic in the global search box » Click the Urgent Care Centers tile for a guided search option. Results will be based on the location searched and present providers that participate with the member's plan.
Urgent Care Centers[2]	Local clinics that treat conditions that aren't life-threatening but require immediate treatment.	• Broken bones • Digital X-rays • Drug tests • EKG test • Lab tests • Minor burns or injuries • PPD/TB skin tests • Pregnancy test • Short-term (acute) illness • Splints • Stitches • Sports & school physicals • Shots & vaccines Plus, symptoms treated at limited services clinics	Days, evenings, weekends	$$$	

continued

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Emergency Room	Full hospital service for severe symptoms that could seriously jeopardize your health or the health of another (including an unborn child).	• Possible heart attack • Stroke • Poisoning • Loss of consciousness	24/7	$$$$$	• Call **911** or go to your nearest hospital

1. Example: CVS Minute Clinic®˜

2. Examples: CareWell®˝ Urgent Care, Doctors Express,®˜ and Health Express

Notes About Limited Services Clinics and Urgent Care Centers:

- If your doctor's office does not offer urgent care as part of their practice, make sure to check Find a Doctor regularly, as new limited services clinics and urgent care centers are always being added. If you're logged into MyBlue, your network will display automatically. If you're using our public Find a Doctor site, be sure to verify the name of your plan, found on your Blue Cross ID card, and click the Which Network Should I Choose? link for additional help.
- Verify that your health plan covers care at the location you choose.
- If you're outside of Massachusetts, use our Find a Doctor and Estimate Costs tool, or call Member Service at the number on the front of your Blue Cross ID card to confirm if the clinic is in our network or if you need a referral.

Telehealth: A Convenient New Benefit

Using your computer, smartphone, or tablet, you can access Telehealth video visits to speak with a doctor anytime you need care, including after business hours and on weekends.

- Your Telehealth doctor can review your medical and behavioral health history, answer questions, and diagnose, treat, and prescribe medication.
- Check our Find a Doctor and Estimate Costs tool to find a doctor who offers Telehealth services or visit **bluecrossma.com/telehealth** to learn more about this benefit.
- To see if you have Telehealth coverage, log into MyBlue or call Member Service at the number on your ID card for more information.

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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Health Savings Accounts

Control, Flexibility, and Peace of Mind

Your health plan includes an option for you to open a Health Savings Account (HSA). Setting up an HSA with your Blue Cross Blue Shield of Massachusetts Saver plan is a great way to control and plan for your health care expenses over the coming years. It gives you the freedom to manage the way you save and spend your health care dollars.

What is an HSA?

HSAs allow you to set aside tax-free dollars that you can save for medical expenses today, tomorrow, and even for retirement.

How does an HSA work?

Your HSA works a lot like a savings account that you use to pay for qualified health care expenses. Money is deposited into the account, and you can spend it when you need it.

Because your health plan has a deductible, the HSA is a great way to set aside funds to minimize your out-of-pocket costs when you get care.

You can use the HSA to pay for qualified medical expenses, such as:

- Qualified medical, dental, and vision services
- Deductible expenses
- Copayments
- Co-insurance

You can also use your HSA funds for some qualified expenses that aren't covered by traditional health plans, such as laser eye surgery. However, if you use the HSA funds for non-qualified services, you'll be responsible for taxes and a penalty.

How much can I contribute to my HSA?

You can fund an HSA within the annual limits set by the Internal Revenue Service (IRS):

Maximum HSA Contribution[1]	Individual	Family
2018	$3,450	$6,900

1. Adjusted annually for inflation. If you're age 55 or older, you can make additional "catch-up" contributions. The "catch-up" contribution limit for 2018 is $1,000.

What are the advantages of an HSA?

HSAs allow you to put money aside for health care expenses, control the funds, and enjoy the benefits of:

- Pre-tax contributions—Reduce your taxable income. For example, if you're in the 30 percent federal tax bracket and contribute $100 each month to your HSA, your taxable income will decrease by $100, saving you $30 in taxes.
- Tax-free growth—Earn interest and build savings tax-free
- Tax-free withdrawals—For qualified medical expenses
- Portability—The funds stay with you if you change employers
- Control—Decide for yourself whether to spend or save
- Investment flexibility—Help your money grow by investing in mutual funds and other securities (check with your HSA administrator for investment rules)
- Retirement savings—Much like an IRA, you can make tax-free contributions to your HSA. However, unlike an IRA, withdrawls from your HSA are tax-free when you withdraw money from your HSA after the age of 65 for qualified medical expenses.

Can I use an HSA to build health care savings?

The money in your HSA is yours, and you control the account. If you leave your employer, your account goes with you and any unused funds roll over from year to year.

This means you can save funds for use in future years—even in retirement. And you can invest the money to help it grow (see your employer for specifics on investing).

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ahealthyme®

Everything to live a healthier life

If you want to know more about your health and how to make it better, ahealthyme is a great place to start. With just a few clicks, we'll show you just what you need to live a healthier life. From a health assessment to wellness workshops and interactive tools, ahealthyme is your personal online resource.

With ahealthyme, managing your health can be as easy as 1, 2, 3:

1. Start with your health assessment

Taking your health assessment is easy and rewarding. Simply answer questions about eight areas of your health. When done, we'll give you a detailed look at your health today and recommend tools and programs that will help improve it based on your answers.

2. Take a wellness workshop

Our self-paced wellness workshops are a fun way to be smart about your health. You'll gain insight on health topics that relate to you and get closer to your wellness goal.

Learn about:

- Healthy eating
- Quitting smoking
- Stress management
- Physical fitness
- Much more

3. Stay motivated and stick to your goals

Maintaining good eating and exercise habits can help keep you on track. With ahealthyme, you can record and track your activities on any computer or smartphone and see how you're doing in real time.

Get Started Now

Go to **www.ahealthyme.com/login** and sign up to begin your journey to healthier living.

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MASSACHUSETTS

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Fitness Benefit

Your Blue Cross Blue Shield of Massachusetts health plan can save you money annually when you participate in a qualified fitness program.

3 Easy Steps to Getting Reimbursed[1]

1. Choose

Start by picking a qualified fitness program.

2. Complete

Once you pay for the program, fill out the attached form.

3. Mail

Send the completed form to the address listed.

A qualified fitness program is:

A full-service health club with a variety of exercise equipment, including:

- Cardiovascular equipment like treadmills and bikes
- Strength-training equipment like free weights and weight machines

What is a qualified expense?

- Membership fees for up to three consecutive months (of one family or individual health club membership)
- Fitness class fees of up to 10 fitness classes (taken by any combination of members enrolled under the same Blue Cross plan)

What doesn't qualify?

You can't receive the fitness reimbursement for expenses for personal training, lessons, coaching, equipment, clothing, or any of the programs below:

- Exercise studios such as martial arts or yoga centers
- Gymnastics, tennis, aerobic, or pool-only facilities
- Country clubs or social clubs
- Sports teams or leagues

Important information:

- The reimbursement can only be submitted once each calendar year, by March 31 of the following calendar year.
- Keep copies of your proof of payment in case we request it from you. Proof of payment includes:
  - Itemized, dated, paid receipts
  - Bank or credit card statements
  - Paycheck stubs, if your payments are automatically deducted from your paycheck
- Proof of payment should include the name of the fitness program, and the individual amounts charged with date paid.
- The dollar amount you receive may be considered taxable income. Consult your tax advisor about how to treat this reimbursement on your taxes.

Be sure to check with your doctor before starting any exercise program.

1. Before starting, check to see if your plan includes the fitness reimbursement benefit. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

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MASSACHUSETTS

Fitness Reimbursement Request[1]

PLEASE PRINT ALL INFORMATION CLEARLY IN BLACK INK

To verify this reimbursement is offered within your plan, please log on to MyBlue® at bluecrossma.com/myblue or call the Member Service number on your ID card. Submit this form by March 31 of the following year.

Subscriber Information (Policyholder)

Identification Number on Your ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial

Address—Number and Street	City	State	Zip Code

Employer's Name

Member and Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth: MM/DD/YY

Mailing Address—Number and Street (if different from subscriber's)	City	State	Zip Code

Gender (color in the entire box)

☐ Male

☐ Female

Claim is for (choose one and color in the entire box):

☐ Subscriber (policyholder) ☐ Ex-Spouse ☐ Other (specify) _____

☐ Spouse (of policyholder) ☐ Dependent (up to age 26)

Name, Address, and Phone Number of Qualified Fitness Program

Total dollars requested: $_____ for (choose one and color in the entire box):

☐ Membership fees. My monthly membership fee is $_____.

☐ Fitness class fees. My fee per class is $_____.

Health Plan Year

1.Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross Blue Shield of Massachusetts about my qualified fitness program. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I certify that I regularly use the qualified program for which I am requesting reimbursement. I understand that Blue Cross may require additional evidence of program participation and proof of payment before reimbursement is provided.

Subscriber's or
Member's Signature: _____ Date: ____/____/____

Questions?

To verify this fitness reimbursement is offered within your plan or for further information, please log onto the **MyBlue** website at **bluecrossma.com/myblue** or call the Member Service number on the front of your ID card.

Complete this form and mail it to:

Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

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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Weight-Loss Benefit

Your Blue Cross Blue Shield of Massachusetts health plan can save you money annually when you participate in a qualified weight-loss program.

3 Easy Steps to Getting Reimbursed[1]

1. Choose

Start by picking a qualified weight-loss program.

2. Complete

Once you pay for the program, fill out the attached form.

3. Mail

Send the completed form with proof of payment to the address listed.

A qualified weight-loss program is:

- Weight Watchers®, an independent company, with in-person meetings
- Hospital-based weight-loss programs

What is a qualified expense?

- Participation fees for up to three months

What doesn't qualify?

- Weight Watchers Online
- Fees paid for individual nutrition-counseling sessions, food, books, videos, or scales

Important Information

- You can claim this three-month benefit once each calendar year for any combination of members enrolled under the same Blue Cross health plan.
- Keep copies of all your submitted paperwork and proof of payment in case we request it from you. Proof of payment includes the following:
  - » Itemized, dated, paid receipts
  - » Weight Watchers paperwork
- Paperwork and proof of payment should include the name of the family member enrolled in the program and the individual amounts charged with date paid.
- The dollar amount you receive may be considered taxable income. Consult your tax advisor about how to treat this reimbursement on your taxes.

Be sure to check with your doctor before starting any weight-loss program.

1. Before starting, check to see if your plan includes the weight-loss benefit. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

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MASSACHUSETTS

Weight-Loss Reimbursement Request[1]

PLEASE PRINT ALL INFORMATION CLEARLY IN BLACK INK

To verify this reimbursement is offered within your plan, please log on to MyBlue® at bluecrossma.com/myblue or call the Member Service number on your ID card. You have until March 31 of the following year to submit this form.

Subscriber Information (Policyholder)

Identification Number on Your ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial

Address—Number and Street	City	State	Zip Code

Employer's Name

Member and Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth: MM/DD/YY

Mailing Address—Number and Street (if different from subscriber's)	City	State	Zip Code

Gender (color in the entire box)

☐ Male

☐ Female

Claim is for (choose one and color in the entire box):

☐ Subscriber (policyholder) ☐ Ex-Spouse ☐ Other (specify)_____

☐ Spouse (of policyholder) ☐ Dependent (up to age 26)

Class or Program Information Required

Attach 8.5" x 11" photocopies of paid receipts from your qualified weight-loss program. Receipts must show Blue Cross Blue Shield of Massachusetts member's name, name or logo of program, amount paid per session(s), and date(s) paid. For qualified Weight Watchers programs, a photocopy of your program Membership Book showing this information is required.

Name, Address, and Phone Number of Qualified Weight-Loss Program	Health Plan Year

Total dollars requested: $ _____

My monthly program participation fee is $ _____

1.Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross Blue Shield of Massachusetts about my qualified weight-loss program. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I certify that I regularly use the qualified program for which I am requesting reimbursement. I understand that Blue Cross may require additional evidence of program participation and proof of payment before reimbursement is provided.

Subscriber's or Member's Signature: _____ Date: ____/____/____

Questions?

To verify this reimbursement is offered within your plan or for further information, please log onto the **MyBlue** website at **bluecrossma.com/myblue** or call the Member Service number on the front of your ID card.

Complete this form and mail it to:

Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

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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Blue Care line℠

We're here for you 24/7

Call **1-888-247-BLUE (2583)** for the Blue Care Line.

We're here for you 24/7

Have a question about your health? You can talk to a professionally trained, registered nurse 24 hours a day, seven days a week. They're ready when you are—even at 4 a.m.

Know your options

Calling the Blue Care Line is a quick way to find out if you need to see a doctor, go to an emergency room, or if you're able to treat it yourself at home.

We'll call you

Depending on your type of illness or injury, the registered nurse will call and follow up to see how you're responding to the self-treatment.

Confidentiality

Your information is kept in accordance with our policy on confidentiality.

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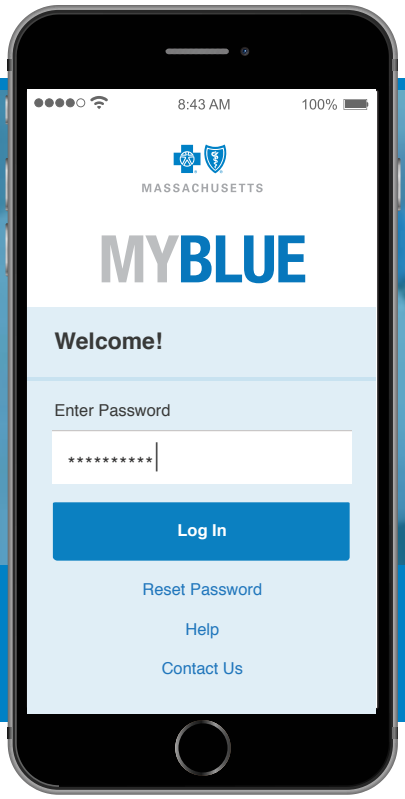

Meet the MYBLUE Member App

Simple, Secure, Convenient

Get Health Care Information Quickly and Easily

The MyBlue Member App gives members instant access to their personal health care information anytime they need it. A simple tap connects them to their doctor, recent prescriptions, and past claims history.

Personalized health care, right at their fingertips:

Use the interactive ID card to direct-dial important numbers, or email a PDF version to a doctor.

Get access to recent claims history and see copayment amounts.

Review recent doctor visits, including date, specialty, and contact information.

See prescriptions history, including dosage and who prescribed it.

Look up and get directions to nearby doctors, dentists, and hospitals.

View dependents under age 18, and keep track of their information.

Available On App Store Google Play

The MyBlue Member App is not available for members with Federal Employee Program (FEP), Blue Benefit Administrators (BBA), Ancillary (Indigo®), Medicare Advantage or stand alone Part D plans, or those with standalone dental, vision, or wellness coverage cannot use the app.

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Nondiscrimination Notice

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. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

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Translation Resources
Proficiency of Language Assistance Services

Spanish/Español: 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**).

Portuguese/Português: 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**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

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Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

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