



MASSACHUSETTS

## SUMMARY OF BENEFITS



# Dental Blue PPO Program 2<sup>®</sup>

JSI, JSI R&T, WEI, Manoff

**Dental Blue<sup>®</sup>**  
*The right choice*

# Dental Blue PPO Program 2

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	\$50 Per Member/\$150 Per Family Calendar Year Deductible	
Full Coverage*	80% Coverage*	50% Coverage*
\$1,000 Calendar-Year Benefit Maximum (network and non-network combined)		
<p><b>Diagnostic</b></p> <ul style="list-style-type: none"> <li>One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures</li> <li>Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months</li> <li>Bitewing X-rays once each six months</li> <li>Single tooth X-rays as needed</li> <li>Study models and casts used in planning treatment once each 60 months</li> <li>Periodic or routine oral exams once each six months</li> <li>Emergency exams</li> </ul> <p><b>Preventive</b></p> <ul style="list-style-type: none"> <li>Routine cleaning, scaling, and polishing of the teeth once each six months</li> <li>Fluoride treatment once each six months (members under age 19)</li> <li>Sealants on permanent pre-molar and molar surfaces (members under age 14) Benefits are provided for one application per bicuspid or molar surface each 48 months</li> <li>Space maintainers needed due to premature tooth loss (members under age 19)</li> </ul>	<p><b>Restorative</b></p> <ul style="list-style-type: none"> <li>Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)</li> <li>Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period)</li> <li>Pin retention for fillings</li> <li>Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)</li> </ul> <p><b>Oral Surgery</b></p> <ul style="list-style-type: none"> <li>Tooth extraction</li> <li>Root removal</li> <li>Biopsies</li> </ul> <p><b>Periodontics (gum and bone)</b></p> <ul style="list-style-type: none"> <li>Periodontal scaling and root planing once per quadrant each 24 months</li> <li>Periodontal surgery once per quadrant each 36 months</li> <li>Periodontal maintenance following active periodontal therapy once each three months</li> </ul> <p><b>Endodontics (roots and pulp)</b></p> <ul style="list-style-type: none"> <li>Root canal therapy (permanent teeth, once per lifetime per tooth)</li> <li>Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth</li> <li>Therapeutic pulpotomy on primary or permanent teeth (members under age 16)</li> <li>Other endodontic surgery to treat or remove the dental root</li> </ul> <p><b>Prosthetic Maintenance</b></p> <ul style="list-style-type: none"> <li>Repair of partial or complete dentures, crowns, and bridges once each 12 months</li> <li>Adding teeth to an existing complete or partial denture</li> <li>Rebase or reline of dentures once each 36 months</li> <li>Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months</li> </ul> <p><b>Other Services</b></p> <ul style="list-style-type: none"> <li>Occlusal adjustments once each 24 months</li> <li>Services to treat root sensitivity</li> <li>Emergency dental care to treat acute pain or to prevent permanent harm to a member**</li> <li>General anesthesia when administered in conjunction with covered surgical services</li> <li>Occlusal Guards</li> </ul>	<p><b>Prosthodontics (teeth replacement)</b></p> <ul style="list-style-type: none"> <li>Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch</li> <li>Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth</li> <li>Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable</li> <li>Adding teeth to an existing bridge</li> <li>Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)</li> </ul> <p><b>Major Restorative (members age 16 or older)</b></p> <ul style="list-style-type: none"> <li>Crowns, once each 60 months for each tooth</li> <li>Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.</li> <li>Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth</li> <li>Replacement of crowns, once each 60 months for each tooth</li> <li>Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.</li> <li>Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth</li> <li>Post and core or crown buildup, once each 60 months for each tooth</li> <li>Single tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars</li> </ul>

\* Benefits are reduced by 20 percent when services are received from a non-network provider.

\*\* Emergency care services are not subject to the calendar-year deductible. When you require emergency care by a non-network dentist, benefits are provided for the same level of benefits that are available for services by a network dentist.

Welcome to Dental Blue PPO Program 2, a dental plan designed to manage the cost of dental services. Dental Blue PPO offers a large network of dentists, including dentists who participate with Blue Cross Blue Shield of Rhode Island and the DenteMax Network of Dentists. Using network dentists will minimize your out-of-pocket expenses.

## Your Dentist

If you already have a dentist and want to know if she or he participates in the Dental Blue PPO network, you can call the dentist, look at the current dental provider directory, or call Member Service at the toll-free phone number shown on your Dental Blue ID card.

If you would like help choosing a dentist, you can call the Physician Selection Service at **1-800-821-1388**. You can also access the online dental provider directory at [www.bluecrossma.com](http://www.bluecrossma.com).

## Your Benefits

The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and benefit maximum amounts shown in the chart. The chart also shows the percentage of costs your plan will pay for covered dental services. Payments are based on whether or not you receive services from a network or non-network dentist.

Many of the covered services have specific time or age limits.

For example:

- Cleanings are provided only once each six months.
- Fluoride treatments are provided only for members under age 19.

## Pre-Treatment Estimates

If your dentist expects that your dental treatment will involve covered services that will cost more than \$250, Blue Cross Blue Shield recommends that your dentist send a copy of the “treatment plan” to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service.

Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year benefit maximum or eligibility status has changed.)

## Multi-Stage Procedures

Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A network dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure.

You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

## How Network Dentists Are Paid

Payments are based on the allowed charge for covered services. Network dentists agree to accept the allowed charge as payment in full. You pay only your deductible and coinsurance (if applicable), and any charges beyond your calendar-year maximum. In certain situations, you will have to pay the difference between the claim payment and the provider’s actual billed charge. Refer to your plan description for information about these situations.

## How Non-Network Dentists Are Paid

Payments are based on 80 percent of the network coverage levels for covered services. Your benefits will be calculated based on the standard allowance that Blue Cross Blue Shield of Massachusetts has established for its indemnity dental product participating dentists. This may sometimes be less than the dentist’s actual charge. You will be responsible for your deductible and coinsurance (if applicable), and the difference between the Blue Cross Blue Shield payment and the dentist’s actual billed charge. If the dentist’s actual charge is less than the allowed charge, your benefits will be calculated based on the dentist’s actual charge.

For example, if 80 percent of your dental expenses would have been covered had you used a network provider, only 64 percent of such expenses will be covered if you use a non-network provider.

This provision does not apply to emergency care services. Benefits for emergency care are paid based on the network level of benefits.

## When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan.

## Dependent Benefits

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

## Domestic Partner Coverage

Domestic partner coverage may be available for eligible dependents. Please contact your plan sponsor for details.

## Enhanced Dental Benefits

Enhanced Dental Benefits for certain dental care services are available for members who have been diagnosed with diabetes, coronary artery disease, oral cancer, or who are pregnant. Contact Member Service for more information.

## If You Have to File a Claim

Network dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist as long as the claims are received within one year of the completed service.

If you receive care from a non-network dentist, you will typically need to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service.

After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

If you have a grievance, please see your plan description for instructions on how to file a grievance.

## Other Information

Coordination of benefits applies to plan members who are covered by another plan for health care expenses. Coordination of benefits ensures that payments from other insurance or health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause, which means that Blue Cross Blue Shield can recover payments if a member has already been paid for the same claim by a third party.

## Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **18003487921**, or visit us online at [www.bluecrossma.com](http://www.bluecrossma.com).

Interested in receiving information from us via e-mail? Go to [www.bluecrossma.com/email](http://www.bluecrossma.com/email) to sign up.

**Limitations and Exclusions.** These pages summarize the benefits of your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.





MASSACHUSETTS

# Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

## Before You Begin

Please carefully read the instructions below.

**For members of HMO Blue,<sup>®</sup> Network Blue,<sup>®</sup> Blue Choice,<sup>®</sup> HMO Blue New England,<sup>SM</sup> or Blue Choice New England<sup>SM</sup>:** You're required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting [bluecrossma.com](http://bluecrossma.com) and selecting **Find a Doctor**.

**For Access Blue<sup>SM</sup> Members:** Although you're not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

**Important:** Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Please be sure to check either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Sections 2 and 3.

Please print two copies of your completed application. Keep one for your records and give the other to your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

**Special Instructions for Student Coverage:** If you're seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

**Blue Cross Blue Shield of Massachusetts**  
P.O. Box 986001  
Boston, MA 02298  
Fax: 1-617-246-7531

# Instructions

## Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

**Type of Transaction**—Check the box(es) that apply.

**Subscriber Cancellation Codes.** If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling	Code #	Reason for Canceling
041	<ul style="list-style-type: none"> <li>• Changing to other health plan</li> <li>• Voluntary termination</li> <li>• COBRA cancellation (under 18 months or nonpayment)</li> </ul>	061	<ul style="list-style-type: none"> <li>• Left employment</li> <li>• COBRA ending</li> </ul>
042	<ul style="list-style-type: none"> <li>• Over 65, changing to Group Medex® plan. (Requires Medicare A and B)</li> <li>• Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B)</li> <li>• Over 65, changing to Medicare supplement other than Medex plans.</li> </ul>	063	• Transfer
043	• Medicare (age =< 65)	064	• Cancellation as of original effective date
		070	• Deceased
		071	• Moved out of state (out of HMO service area)
		076	• Military service

**Note:** If your subscribers are adding or dropping one benefit only (medical/dental), please indicate “add medical,” “add dental,” “cancel medical,” or “cancel dental” in the “Remarks” section.

If your new hires are subject to a probationary period, please indicate the time frame in the “Remarks” section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

### Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the “Remarks” section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions, contact your account service representative.
- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation. If you have questions, contact your account service representative.

## Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)\*

**PCP ID#**—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (*not* the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at 1-800-821-1388. A representative will be happy to help you select a doctor. PCP ID number can be found at [bluecrossma.com](http://bluecrossma.com), select **Find a Doctor**.

**Other Insurance**—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If you have other insurance, please write the name of the other insurance company and your member identification number.

**To Add or Delete a Member**—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

## Section 3 Member 2

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)\* (Note: Member 2 cannot be covered under an **Individual** membership.)

**Other Insurance**—Does your spouse have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

## Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a **Family** membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)\* (Note: dependents cannot be covered under an **Individual** membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

## Section 5 Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

**For each option:**

**Start Date:** Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated, and submitted the completed application for these accounts on or before that date.

**End Date:** Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions, please see your employer.

**Note:** If you are transferring from one medical/dental plan to another plan, please complete Section 5 of the Enrollment and Change Form to let us know that you will be continuing your personal savings account.

## Section 6 Signatures (Employer & Employee)

**Employee:** Please sign and date the application and return it to your employer. **Employer:** Please sign and date the application and return to Blue Cross Blue Shield of Massachusetts. Please mail to:

P.O. Box 986001  
Boston, MA 02298  
or fax to 1-617-246-7531

\* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

**Please Read the Instructions Before Filling Out This Form.**



**Enrollment and Change Form**

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

**MASSACHUSETTS**

Please mail to: P.O. Box 986001  
Boston, MA 02298 or fax to 1-617-246-7531

**1. To Be Filled Out by Your Employer**

Company Name		Current Medical Group #:			Medical Group # Transferring To:		
Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY		Current Dental Group #:	Dental Group # Transferring To		
Type of Transaction <input type="checkbox"/> ADD <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER		Remarks: (i.e., qualifying event for a new add, change to family or other instruction) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> COBRA			Change to Family <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent		<input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter required) <input type="checkbox"/> Other: _____

**2. Yourself (Member 1)**

What products? <input type="checkbox"/> Access Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> Blue Choice New England	<input type="checkbox"/> Blue Medicare Rx (Part D) <input type="checkbox"/> Dental Blue <input type="checkbox"/> HMO Blue	<input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Managed Blue for Seniors <input type="checkbox"/> Medex (Group)	<input type="checkbox"/> Network Blue <input type="checkbox"/> PPO <input type="checkbox"/> Saver Blue	<del>Membership Type (Medical)</del> <input type="checkbox"/> Individual <input type="checkbox"/> Family	Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family
First Name	M.I.	Last Name		Sex	Date of Birth
Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code	
Home Phone ( )	Cell Phone ( )	Email			
Social Security # (REQUIRED) <sup>1</sup>	Other Insurance? <sup>2</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	Member Identification Number		
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		
Are you covered by Medicare? <sup>2</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date

**3. Member 2**

Please Check One:  Spouse  Domestic Partner  Divorced Spouse (court ordered) Plan Type:  Medical  Dental

First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	Phone ( )	Other Insurance? <sup>1</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	Member Identification Number	
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		
Are you covered by Medicare? <sup>2</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date

**4. Your Eligible Dependents (Member 3, 4 and 5)**

Dependent's First Name 3.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP		Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent's First Name 4.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP		Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent's First Name 5.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP		Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	

Please check if you are using separate forms for additional dependent children  Total # of dependents: \_\_\_\_\_

**5. Personal Savings Account**

<input type="checkbox"/> HSA: Health Savings Account	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): \$
<input type="checkbox"/> FSA: Health Flexible Spending Account	Start Date	End Date	Health: \$
<input type="checkbox"/> FSA: Dependent Care Reimbursement Account	Start Date	End Date	Dependent Care: \$

**6. Signature (Employer & Employee)**

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_ Employer's Signature \_\_\_\_\_ Date \_\_\_\_\_

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

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