



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 bluecrossma.org/coverage-info. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call 1-800-588-5508 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u>? | \$250 member / \$500 family in-network; \$250 member / \$500 family out-of-network. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, <u>prescription drugs</u> ; emergency room. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | \$1,000 member / \$2,500 family in-network; \$3,500 member / \$7,000 family out-of-network. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 | \$10 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable |
| | <u>Specialist</u> visit | \$10 / visit; \$10 / chiropractor visit; \$10 / acupuncture visit | 20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit | <u>Deductible</u> applies first for out-of-network; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable |
| | <u>Preventive care/screening/immunization</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> may be required |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> may be required |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|--|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at bluecrossma.org/medication | Generic drugs | \$5 / retail supply or \$10 / mail service supply | Not covered | Up to 30-day retail (90-day mail service) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs |
| | Preferred brand drugs | \$15 / retail supply or \$30 / mail service supply | Not covered | |
| | Non-preferred brand drugs | \$25 / retail supply or \$50 / mail service supply | Not covered | |
| | <u>Specialty drugs</u> | Applicable <u>cost share</u> (generic, preferred, non-preferred) | Not covered | When obtained from a designated specialty pharmacy; <u>cost share</u> may be waived or reduced for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| If you need immediate medical attention | <u>Emergency room care</u> | \$50 / visit; <u>deductible</u> does not apply | \$50 / visit; <u>deductible</u> does not apply | <u>Copayment</u> waived if admitted or for observation stay |
| | <u>Emergency medical transportation</u> | No charge | No charge | In-network <u>deductible</u> applies first for in-network and out-of-network services |
| | <u>Urgent care</u> | \$10 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|--|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$10 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | Inpatient services | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services |
| If you are pregnant | Office visits | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable |
| | Childbirth/delivery professional services | No charge | 20% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | No charge | 20% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|---|--|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required |
| | <u>Rehabilitation services</u> | \$10 / visit for outpatient services; No charge for inpatient services | 20% <u>coinsurance</u> for outpatient services; 20% <u>coinsurance</u> for inpatient services | <u>Deductible</u> applies first except for in-network outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | <u>Habilitation services</u> | \$10 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable |
| | <u>Skilled nursing care</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth, including supplies (20% <u>coinsurance</u> for out-of-network) |
| | <u>Hospice services</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|---|--|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to one exam every 24 months |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | No charge for members with a cleft palate / cleft lip condition | 20% <u>coinsurance</u> for members with a cleft palate / cleft lip condition | <u>Deductible</u> applies first for out-of-network; limited to members under age 18 |

Excluded Services & Other Covered Services:

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

- | | | |
|----------------------|-----------------------|------------------------|
| • Children's glasses | • Dental care (Adult) | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | |

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

- | | | |
|--|---|---|
| • Acupuncture (12 visits per calendar year) | • Infertility treatment | • Routine foot care (only for patients with systemic circulatory disease) |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (\$150 per calendar year per policy) |
| • Chiropractic care | • Routine eye care - adult (one exam every 24 months) | |
| • Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger) | | |

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.ccio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-472-2689 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.) You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



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

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Delivery fee copay</u> | \$0 |
| ■ <u>Facility fee copay</u> | \$0 |
| ■ <u>Diagnostic tests copay</u> | \$0 |

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost sharing</u> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$320 |

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Specialist visit copay</u> | \$10 |
| ■ <u>Primary care visit copay</u> | \$10 |
| ■ <u>Diagnostic tests copay</u> | \$0 |

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost sharing</u> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$100 |
| <u>Copayments</u> | \$700 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$820 |

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Specialist visit copay</u> | \$10 |
| ■ <u>Emergency room copay</u> | \$50 |
| ■ <u>Ambulance services copay</u> | \$0 |

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost sharing</u> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$100 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$350 |

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

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