This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bluecrossma.com or by calling **1-888-753-6615.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for how much you pay for covered services.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** member / **$10,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments less than $100 per visit, prescription drugs, premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan pays for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor or call **1-800-821-1388** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	20% coinsurance	—— none ——
	Specialist visit	$15 / visit	20% coinsurance	—— none ——
	Other practitioner office visit	$15 / chiropractor visit	20% coinsurance / chiropractor visit	—— none ——
	Preventive care/screening/immunization	No charge	20% coinsurance	Limited to age-based schedule and / or frequency
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	—— none ——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	—— none ——

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com.	Generic drugs	$10 / retail supply or mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share waived for birth control; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply pre-authorization required for certain drugs
	Non-preferred brand drugs	$45 / retail supply or mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	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)	$50 / admission	20% coinsurance	—— none ——
	Physician/surgeon fees	No charge	20% coinsurance	—— none —
If you need immediate medical attention	Emergency room services	$50 / visit	$50 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	10% coinsurance	10% coinsurance	—— none ——
	Urgent care	$15 / visit	20% coinsurance	—— none ——
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-authorization required
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Pre-authorization required

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 / visit	20% coinsurance	Limited to 24 visits per calendar year for certain non-biologically based conditions
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Limited to 60 days per calendar year for certain non-biologically based conditions; pre-authorization required
	Substance use disorder outpatient services	$15 / visit	20% coinsurance	—— none ——
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Pre-authorization required
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care; 10% coinsurance for postnatal care	20% coinsurance for prenatal care; 30% coinsurance for postnatal care	—— none ——
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	—— none ——

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Pre-authorization required
	Rehabilitation services	$15 / visit	20% coinsurance	Limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	$15 / visit	20% coinsurance	Rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	10% coinsurance	30% coinsurance	Limited to $1,500 per calendar year; in-network cost share and coverage limit waived for one breast pump per birth (20% coinsurance out-of-network, no coverage limit)
	Hospice service	10% coinsurance	30% coinsurance	Pre-authorization required for certain services
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Limited to one exam every 24 months
	Glasses	Not covered	Not covered	—— none ——
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Cosmetic surgery	• Long-term care
• Children's glasses	• Dental care (adult)	• Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Infertility treatment	• Routine foot care (only for patients with systemic circulatory disease)
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Weight loss programs ($150 per policy per calendar year)
• Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)	• Routine eye care - adult (one exam every 24 months)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: 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.

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiiłné t'áá jííkeh béésh bee' hane'jį T'áá doolé'é bina'íshdiłkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

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 page.