



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.bluecrossma.com/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 www.bluecrossma.com/sbcglossary or call 1-888-753-6615 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u>? | \$0 PCP / Plan-Approved; \$250 member Self-Referred. | 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. |
| Are there services covered before you meet your <u>deductible</u>? | Yes. Emergency room and emergency transportation. | 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>? | For medical benefits, \$3,000 member / \$6,000 family; and for prescription drug benefits, \$1,000 member / \$2,000 family. | 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>? | Premiums, balance-billing charges, and health care this plan 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 www.bluecrossma.com/findadoct or call 1-800-821-1388 for a list of network providers. | 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>? | Yes, PCP / Plan-Approved level of benefits only. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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 |
|---|--|---|---|---|
| | | PCP/Plan-Approved (You will pay the least) | Self-Referred (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% coinsurance | Deductible applies first for Self-Referred |
| | <u>Specialist</u> visit | \$10 / visit; \$10 / chiropractor visit | 20% coinsurance; 20% coinsurance / chiropractor visit | Deductible applies first for Self-Referred |
| | <u>Preventive care/screening/immunization</u> | No charge | 20% coinsurance | Deductible applies first for Self-Referred; 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 | <u>Diagnostic test</u> (x-ray, blood work) | No charge | 20% coinsurance | Deductible applies first for Self-Referred |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required for certain services |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bluecrossma.com/medications | Generic drugs | \$10 / retail or 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 | \$20 / retail or mail service supply | Not covered | |
| | Non-preferred brand drugs | \$35 / retail or mail service supply | Not covered | |
| | <u>Specialty drugs</u> | 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 |
|--|--|--|---------------------------------------|--|
| | | PCP/Plan-Approved (You will pay the least) | Self-Referred (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required for certain services |
| | Physician/surgeon fees | No charge | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required for certain services |
| If you need immediate medical attention | <u>Emergency room care</u> | \$25 / visit | \$25 / visit | Copayment waived if admitted or for observation stay |
| | <u>Emergency medical transportation</u> | No charge | No charge | None |
| | <u>Urgent care</u> | \$10 / visit | 20% coinsurance | Deductible applies first for Self-Referred |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required |
| | Physician/surgeon fees | No charge | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$10 / visit | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required for certain services |
| | Inpatient services | No charge | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required for certain services |
| If you are pregnant | Office visits | No charge | 20% coinsurance | Deductible applies first for Self-Referred; 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 |
|---|----------------------------------|--|---------------------------------------|---|
| | | PCP/Plan-Approved (You will pay the least) | Self-Referred (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required |
| | <u>Rehabilitation services</u> | \$10 / visit | 20% coinsurance | Deductible applies first for Self-Referred; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services |
| | <u>Habilitation services</u> | \$10 / visit | 20% coinsurance | Deductible applies first for Self-Referred; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); cost share and coverage limits waived for early intervention services for eligible children; pre-authorization may be required for certain services |
| | <u>Skilled nursing care</u> | No charge | 20% coinsurance | Deductible applies first for Self-Referred; limited to 100 days per calendar year; pre-authorization required |
| | <u>Durable medical equipment</u> | 20% coinsurance | 20% coinsurance | Deductible applies first for Self-Referred; PCP / Plan-Approved cost share waived for one breast pump per birth |
| | <u>Hospice services</u> | No charge | 20% coinsurance | Deductible applies first for Self-Referred; pre-authorization required for certain services |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|--|---------------------------------------|--|
| | | PCP/Plan-Approved (You will pay the least) | Self-Referred (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | 20% coinsurance | Deductible applies first for Self-Referred; limited to one exam every 12 months until the end of the month a member turns age 19 |
| | Children's glasses | 35% coinsurance | 50% coinsurance | Deductible applies first for Self-Referred; limited to one set of prescription lenses and / or frames or contact lenses per calendar year until the end of the month a member turns age 19 |
| | Children's dental check-up | No charge | Not covered | Limited to twice per calendar year until the end of the month a member turns age 19 |

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.) | | |
|--|--|---|
| <ul style="list-style-type: none"> Acupuncture Cosmetic surgery | <ul style="list-style-type: none"> Dental care (Adult) Long-term care | <ul style="list-style-type: none"> Private-duty nursing |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none"> Bariatric surgery Chiropractic care Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger) | <ul style="list-style-type: none"> Infertility treatment Non-emergency care when traveling outside the U.S. Routine eye care - adult (one exam every 24 months) | <ul style="list-style-type: none"> Routine foot care (only for patients with systemic circulatory disease) Weight loss programs (three months in qualified program(s) per contract per calendar year) |

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 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 the state marketplace, please contact the Massachusetts Health Connector at www.mahealthconnector.org. For more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583).

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.) 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]

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 | \$0 |
| ■ 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 | \$0 |
| Copayments | \$16 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|-------------|
| The total Peg would pay is | \$76 |
|-----------------------------------|-------------|

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---------------------------------|------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist visit copay | \$10 |
| ■ Primary care visit copay | \$10 |
| ■ 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 | \$0 |
| Copayments | \$1,080 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$55 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$1,135 |
|-----------------------------------|----------------|

Jacque's Simple Fracture

(in-network emergency room visit and follow-up care)

| | |
|---------------------------------|------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist visit copay | \$10 |
| ■ Emergency room copay | \$25 |
| ■ 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 | \$0 |
| Copayments | \$75 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|---------------------------------------|-------------|
| The total Jacquie would pay is | \$75 |
|---------------------------------------|-------------|

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

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MASSACHUSETTS

MCC Compliance



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.



MASSACHUSETTS

Pediatric Dental

Your health plan coverage includes a dental policy that covers pediatric dental services as required under the federal Patient Protection and Affordable Care Act.



MASSACHUSETTS

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 civilrightscordinator@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.



MASSACHUSETTS

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 Idantifikasyon 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/عربي:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (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/λληνικά: 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**).

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 કોલ 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 شماره تلفن مندرج بروی 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 yánílt'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'ígíjij' béeesh bee hodíílnih (TTY: 711).