



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 **1-800-782-3675**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible ? | \$0 | See the chart starting on page 2 for your costs for services this plan covers. |
| 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. \$2,000 member / \$4,000 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 \$100 or less, 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 will pay for <i>specific</i> 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 ? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist . |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services . |

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- **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 stay is \$1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- 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 enhanced benefits tier **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 |
|---|--|---------------------------|----------------------------|----------------------------|----------------|---|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | 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 | \$25 / visit | \$45 / visit | Not covered | —— none —— |
| | Specialist visit | \$45 / visit | \$45 / visit | \$45 / visit | Not covered | —— none —— |
| | Other practitioner office visit | \$45 / chiropractor visit | \$45 / chiropractor visit | \$45 / chiropractor visit | Not covered | Limited to 12 visits per calendar year for members age 16 or older |
| | Preventive care/screening/immunization | No charge | No charge | No charge | Not covered | GYN exam limited to one exam per calendar year |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | No charge | No charge | Not covered | —— none —— |
| | Imaging (CT/PET scans, MRIs) | \$75 | \$75 (\$150 for hospitals) | \$75 (\$250 for hospitals) | Not covered | Copayment applies per category of test / day; pre-authorization required for certain services |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|--|--|--|--|--|----------------|---|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | 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 | \$15 / retail or \$30 / mail service supply | \$15 / retail or \$30 / mail service supply | \$15 / retail or \$30 / 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 | \$30 / retail or \$60 / mail service supply | \$30 / retail or \$60 / mail service supply | \$30 / retail or \$60 / 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 | \$50 / retail or \$150 / mail service supply | \$50 / retail or \$150 / mail service supply | \$50 / retail or \$150 / mail service supply | Not covered | Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs |
| | Specialty drugs | \$30 / supply | \$30 / supply | \$30 / supply | Not covered | Up to 30-day supply; pre-authorization required for certain drugs |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$150 / admission | \$150 / admission (\$250 for hospitals) | \$150 / admission (\$500 for hospitals) | Not covered | Pre-authorization required for certain services |
| | Physician/surgeon fees | No charge | No charge | No charge | Not covered | Pre-authorization required for certain services |
| If you need immediate medical attention | Emergency room services | \$150 / visit | \$150 / visit | \$150 / visit | \$150 / visit | Copayment waived if admitted or for observation stay |
| | Emergency medical transportation | No charge | No charge | No charge | No charge | —— none —— |
| | Urgent care | \$45 / visit | \$45 / visit | \$45 / visit | \$45 / visit | Out-of-network coverage limited to out of service area |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|--|--|------------------------|--|---|----------------|---|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 / admission | \$500 / admission (\$300 for selected hospitals) | \$1,000 / admission | Not covered | Pre-authorization required |
| | Physician/surgeon fee | No charge | No charge | No charge | Not covered | Pre-authorization required |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$15 / visit | \$15 / visit | \$15 / visit | Not covered | Pre-authorization required for certain services |
| | Mental/Behavioral health inpatient services | \$250 / admission | \$250 / admission (\$500 for general hospitals) | \$250 / admission (\$1,000 for general hospitals) | Not covered | Pre-authorization required |
| | Substance use disorder outpatient services | \$15 / visit | \$15 / visit | \$15 / visit | Not covered | Pre-authorization required for certain services |
| | Substance use disorder inpatient services | \$250 / admission | \$250 / admission (\$500 for general hospitals) | \$250 / admission (\$1,000 for general hospitals) | Not covered | Pre-authorization required |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|--|-------------------------------------|--|---|--|----------------|--|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| If you are pregnant | Prenatal and postnatal care | No charge | No charge | No charge | Not covered | —— none —— |
| | Delivery and all inpatient services | \$250 / admission and no charge for delivery | \$500 / admission (\$300 for selected hospitals) and no charge for delivery | \$1,000 / admission and no charge for delivery | Not covered | —— none —— |
| If you need help recovering or have other special health needs | Home health care | No charge | No charge | No charge | Not covered | Pre-authorization required |
| | Rehabilitation services | \$45 / visit | \$45 / visit | \$45 / 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 | \$45 / visit | \$45 / visit | \$45 / 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 | No charge | No charge | Not covered | Limited to 100 days per calendar year; pre-authorization required |
| | Durable medical equipment | No charge | No charge | No charge | Not covered | Limited to \$750 per calendar year; coverage limit waived for one breast pump per birth |
| | Hospice service | No charge | No charge | No charge | Not covered | Pre-authorization required for certain services |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|--|-----------------------|------------------------|------------------------|---------------------|----------------|--|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| If your child needs dental or eye care | Eye exam | No charge | No charge | No charge | Not covered | Limited to one exam every 24 months |
| | Glasses | Not covered | Not covered | Not covered | Not covered | ——— none ——— |
| | Dental check-up | No charge | No charge | No charge | Not covered | Limited to children under age 18 with a cleft palate / cleft lip condition |

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
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limited to 12 visits per calendar year for members age 16 or older)
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (limited to one exam every 24 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:

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.

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 hodiilné t'áá jííkeh béesh bee' hane'jí T'áá doolé'é bina'ishdiłkidgo yeeháka'adooljah 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.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,040
- Patient Pays \$500

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient Pays:

| | |
|----------------------|--------------|
| Deductibles | \$0 |
| Copays | \$500 |
| Coinsurance | \$0 |
| Limits or exclusions | \$0 |
| Total | \$500 |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,110
- Patient Pays \$2,290

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient Pays:

| | |
|----------------------|----------------|
| Deductibles | \$0 |
| Copays | \$1,740 |
| Coinsurance | \$0 |
| Limits or exclusions | \$550 |
| Total | \$2,290 |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-262-BLUE (2583).

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from standard benefits tier **providers**. If the patient had received care from other in-network or out-of-network **providers**, costs would have been different.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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MASSACHUSETTS

MCC Compliance

- ✓ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, as part of the Massachusetts Health Care Reform Law.



Information About the Plan

This health plan includes a tiered provider network called HMO Blue Options v.4. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at www.bluecrossma.com/findadoctor and search for HMO Blue Options v.4.