




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.emiia.org](http://www.emiia.org). 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](http://bluecrossma.org/sbcglossary) or call 1-800-782-3675 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$300 member / \$900 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive care, prenatal care, prescription drugs, most office visits, certain mental health services, and therapy visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For medical benefits, \$2,500 member / \$5,000 family; and for prescription drug benefits, \$1,000 member / \$2,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billing 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.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do you need a referral to see a specialist?</b>	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

 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	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
	Specialist visit	\$60 / visit; \$20 / chiropractor visit; \$60 / acupuncture visit	Not covered	Limited to 20 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; 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	Diagnostic test (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$100	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a></p>	Generic drugs	\$10 / retail supply or \$25 / designated retail or mail service supply	Not covered	<p>This plan uses the Blue Cross Blue Shield of Massachusetts Formulary – Focused; up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs</p>
	Preferred brand drugs	\$30 / retail supply or \$75 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$65 / retail supply or \$165 / designated retail or mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	Not covered	<p>This plan uses the Blue Cross Blue Shield of Massachusetts Formulary – Focused when obtained from a designated specialty pharmacy; <u>cost share</u> may be waived, reduced, or increased for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs</p> <p><u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services</p>
	Physician/surgeon fees	No charge	Not covered	
	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	
<p><b>If you need immediate medical attention</b></p>	<u>Emergency medical transportation</u>	No charge	No charge	<p><u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay</p> <p><u>Deductible</u> applies first</p> <p>Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable</p>
	<u>Urgent care</u>	\$60 / visit	\$60 / visit	

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$275 / admission; \$1,500 / admission for certain hospitals	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 / visit	Not covered	<u>Cost share</u> may be waived or reduced for certain services; a <u>telehealth cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$275 / admission; \$1,500 / admission for certain hospitals	Not covered	<u>Deductible</u> applies first for general hospitals; <u>pre-authorization</u> / authorization required for certain services
<b>If you are pregnant</b>	Office visits	No charge	Not covered	<u>Deductible</u> applies first except for prenatal care; <u>cost sharing</u> does not apply for <u>preventive services</u> ;
	Childbirth/delivery professional services  Childbirth/delivery facility services	No charge  \$275 / admission; \$1,500 / admission for certain hospitals	Not covered  Not covered	maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a <u>telehealth 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)	
<p><b>If you need help recovering or have other special health needs</b></p>	<u>Home health care</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	\$20 / visit for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first except for outpatient services; limited to 30 outpatient visits per type of therapy per calendar year (other than for autism, Down syndrome, <u>home health care</u> , and speech therapy); a <u>telehealth cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$20 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a <u>telehealth cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; limited to 45 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<p><b>If your child needs dental or eye care</b></p>	Children's eye exam	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

**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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

**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)
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Hearing aids (\$5,000 per ear every 36 months)
- Infertility treatment
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$300 per calendar year per policy)

**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](http://www.dol.gov/ebsa/healthreform) and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.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](http://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](http://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](http://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 1-800-782-3675 or contact your [plan sponsor](#). (A [plan sponsor](#) is usually the member's employer or organization that provides group health coverage to the member.)

**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 plan's overall deductible** \$300
- **Delivery fee copay** \$0
- **Facility fee copay** \$275
- **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** \$12,700

**In this example, Peg would pay:**

<i>Cost sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$660</b>

**Managing Joe's Type 2 Diabetes**

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

- **The plan's overall deductible** \$300
- **Specialist visit copay** \$60
- **Primary care visit copay** \$20
- **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** \$5,600

**In this example, Joe would pay:**

<i>Cost sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,320</b>

**Mia's Simple Fracture**

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

- **The plan's overall deductible** \$300
- **Specialist visit copay** \$60
- **Emergency room copay** \$100
- **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** \$2,800

**In this example, Mia would pay:**

<i>Cost sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

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

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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

## INFORMATION ABOUT THE PLAN

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This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of cost share (such as copayments and coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from some network general hospitals, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at [bluecrossma.org/hospitalchoice](https://bluecrossma.org/hospitalchoice).

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