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 **1-800-241-0803**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** In-Network; **$500** member / **$1,000** family Out-of-Network. Does not apply to emergency room, emergency transportation.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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. **$1,000** member / **$2,000** family for Out-of-Network.	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?	**Deductible**, copayments, 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 *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 preferred 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 5. 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 **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are a group member and 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	$25 / visit	20% coinsurance	——— none ———
	Specialist visit	$25 / visit	20% coinsurance	——— none ———
	Other practitioner office visit	$25 / chiropractor visit	20% coinsurance / chiropractor visit	——— none ———
	Preventive care/screening/immunization	No charge	20% coinsurance	Limited to age based and/or frequency limit
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	$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	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 $100 / 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	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)	$250 / admission	20% coinsurance	——— none ———
	Physician/surgeon fees	No charge	20% coinsurance	——— none ———
If you need immediate medical attention	Emergency room services	$100 / visit	$100 / visit	——— none ———
	Emergency medical transportation	No charge	No charge	——— none ———
	Urgent care	$25 / visit	20% coinsurance	——— none ———
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	20% coinsurance	Pre-authorization required
	Physician/surgeon fee	No charge	20% coinsurance	Pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 / visit	20% coinsurance	——— none ———
	Mental/Behavioral health inpatient services	$500 / admission	20% coinsurance	Pre-authorization required
	Substance use disorder outpatient services	$25 / visit	20% coinsurance	——— none ———
	Substance use disorder inpatient services	$500 / admission	20% coinsurance	Pre-authorization required
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Applies only to prenatal care
	Delivery and all inpatient services	$500 / admission and no charge for delivery	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 help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Pre-authorization required
	Rehabilitation services	$25 / visit	20% coinsurance	Limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	$25 / visit	20% coinsurance	Rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	No charge	20% coinsurance	Limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	20% coinsurance	Limited to $750 per calendar year
	Hospice service	No charge	20% coinsurance	——— none ———
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	Not covered	Not covered	——— none ———

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 dental check-up	• Dental care (adult)	• Private-duty nursing
• Children's glasses		

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

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.state.ma.us/dph/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'jị 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.

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** $7,040
- **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** $3,110
- **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	$1,680
Coinsurance	$260
Limits or exclusions	$0
Total	**$1,940**

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 in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

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.

Questions: Call **1-800-241-0803** or visit us at www.bluecrossma.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call **1-800-241-0803** to request a copy.

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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.

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