



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.bellinghamma.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 or call 1-800-782-3675 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$300 member / \$900 family.	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. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive care</u> , prenatal care, <u>prescription drugs</u> , most office visits, mental health visits, therapy visits.	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/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	\$2,500 member / \$5,000 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.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	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.
<u>Do you need a referral to see a specialist?</u>	Yes.	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
		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
	<u>Specialist</u> visit	\$35 / visit; \$20 / chiropractor visit; \$35 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per <u>plan</u> year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	GYN exam limited to one exam per <u>plan</u> 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	<u>Diagnostic test</u> (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)	\$50	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)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$25 / designated retail or mail service supply	Not covered	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
	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	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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	<u>Deductible</u> applies first
	<u>Urgent care</u>	\$35 / visit	\$35 / visit	Out-of-network coverage limited to out of service area; a telehealth <u>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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / admission	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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$500 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you are pregnant	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> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$500 / admission	Not covered	

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 need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services 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 60 outpatient visits per <u>plan</u> year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per <u>plan</u> year for inpatient admissions; a telehealth <u>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; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Deductible</u> applies first; limited to 100 days per <u>plan</u> year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	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
If your child needs dental or eye care	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 plan year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (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: 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 and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.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. 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 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. 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)

■ <u>The plan's overall deductible</u>	\$300
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$500
■ <u>Diagnostic tests copay</u>	\$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
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$860

Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist visit copay</u>	\$35
■ <u>Primary care visit copay</u>	\$20
■ <u>Diagnostic tests copay</u>	\$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
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist visit copay</u>	\$35
■ <u>Emergency room copay</u>	\$100
■ <u>Ambulance services copay</u>	\$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
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$500

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.

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