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 **1-800-932-8323**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** member / **$750** family. Does not apply to preventive care, prenatal care, prescription drugs, most office visits, mental health visits, and therapy visits.	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. **$5,000** member / **$10,000** 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?	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**.
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 6. See your policy or plan document for additional information about **excluded services**.

- **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 hospital 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 lowest cost share **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
		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	$20 / visit	Not covered	—— none ——
	Specialist visit	$35 / visit	Not covered	—— none ——
	Other practitioner office visit	$20 / chiropractor visit	Not covered	—— none ——
	Preventive care/screening/immunization	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	Not covered	Deductible applies first
	Imaging (CT/PET scans, MRIs)	$100 for hospitals; $75 for services in Connecticut; no charge for other providers	Not covered	Deductible applies first; copayment applies per category of test / day; limited to $375 per calendar year for services in Connecticut; pre-authorization required for certain services

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	$10 / retail supply or $20 / 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	$25 / retail supply or $50 / 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
	Non-preferred brand drugs	$50 / retail supply or $110 / 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
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room services	$100 / visit	$100 / visit	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$35 / visit	$35 / 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
		In-Network	Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 / admission; $700 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fee	No charge	Not covered	Deductible applies first; pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Mental/Behavioral health inpatient services	$200 / admission for mental hospitals or substance abuse facilities; $300 / admission for general hospitals; $700 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization required
	Substance use disorder outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Substance use disorder inpatient services	$200 / admission for mental hospitals or substance abuse facilities; $300 / admission for general hospitals; $700 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization required
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Deductible applies first for postnatal care
	Delivery and all inpatient services	$300 / admission; $700 / admission for certain hospitals; no charge for delivery	Not covered	Deductible applies first

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	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / 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	$20 / 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	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Deductible applies first; cost share waived for one breast pump per birth
	Hospice service	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every 24 months
	Glasses	Not covered	Not covered	—— none ——
	Dental check-up	No charge	Not covered	Limited to children under age 12 (one exam every 6 months) and 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	• Dental care (adult)	• Private-duty nursing
• Children's glasses	• Long-term care	
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	

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	• Infertility treatment	• Weight loss programs ($150 per calendar year per policy)
• Chiropractic care	• Routine eye care - adult (one exam every 24 months)	
• Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)	• Routine foot care (only for patients with systemic circulatory disease)	

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.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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'jį 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 will also 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** $6,820
- **Patient pays** $720

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	$250
Copays	$320
Coinsurance	$0
Limits or exclusions	$150
Total	**$720**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,100
- **Patient pays** $2,300

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	$140
Copays	$2,080
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,300**

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 by 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 lowest cost share **providers**. If the patient had received care from other in-network or 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 should also 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 **1-800-932-8323** 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 **1-800-932-8323** 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, 2014, as part of the Massachusetts Health Care Reform Law.

#139512BS
55-0647 (6/14) 150M

MASSACHUSETTS

Information About the Plan

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 in-network cost share (such as copayments and coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from some preferred general hospitals, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **www.bluecrossma.com/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

#139504BS
55-0531 (6/14) 5M