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The Guide to Your Summary of Benefits and Coverage (SBC) (4/1/17)

Under the Affordable Care Act (ACA), health insurers and group health plans are required to provide an SBC to consumers. This regulation is intended to give consumers clear and consistent information about their health plan and help them better understand and evaluate their choices. The SBC will only include a description of benefits that we insure or administer, and not a description of benefits that accounts delegate to another third-party insurer or administrator.

The SBC is only a summary of benefits and coverage and does not replace the Evidence of Coverage (EOC), subscriber certificate, or plan description that details the full terms of the coverage policy. We will continue to provide the EOC to our insured account subscribers.

This guide gives an overview of the Summary of Benefits and Coverage (SBC) format and the information it contains effective April 1, 2017.

This page of the SBC answers frequently asked questions about your benefit plan. Here you can find out your effective date, deductible information, if a referral is needed, and what your out-of-pocket expenses may be.

This link provides access to the coverage policy documents for fully insured plans. For self-insured plans, the account must provide the web address for this information or it will be left blank.

Members can find answers to key questions about their health plan: how it works, their deductible amount, out-of-pocket maximum, referral requirements, and more.

For plans with an overall medical deductible, this section explains the dollar limits of the deductible for individual and family.

This question addresses what services are not subject to the deductible.

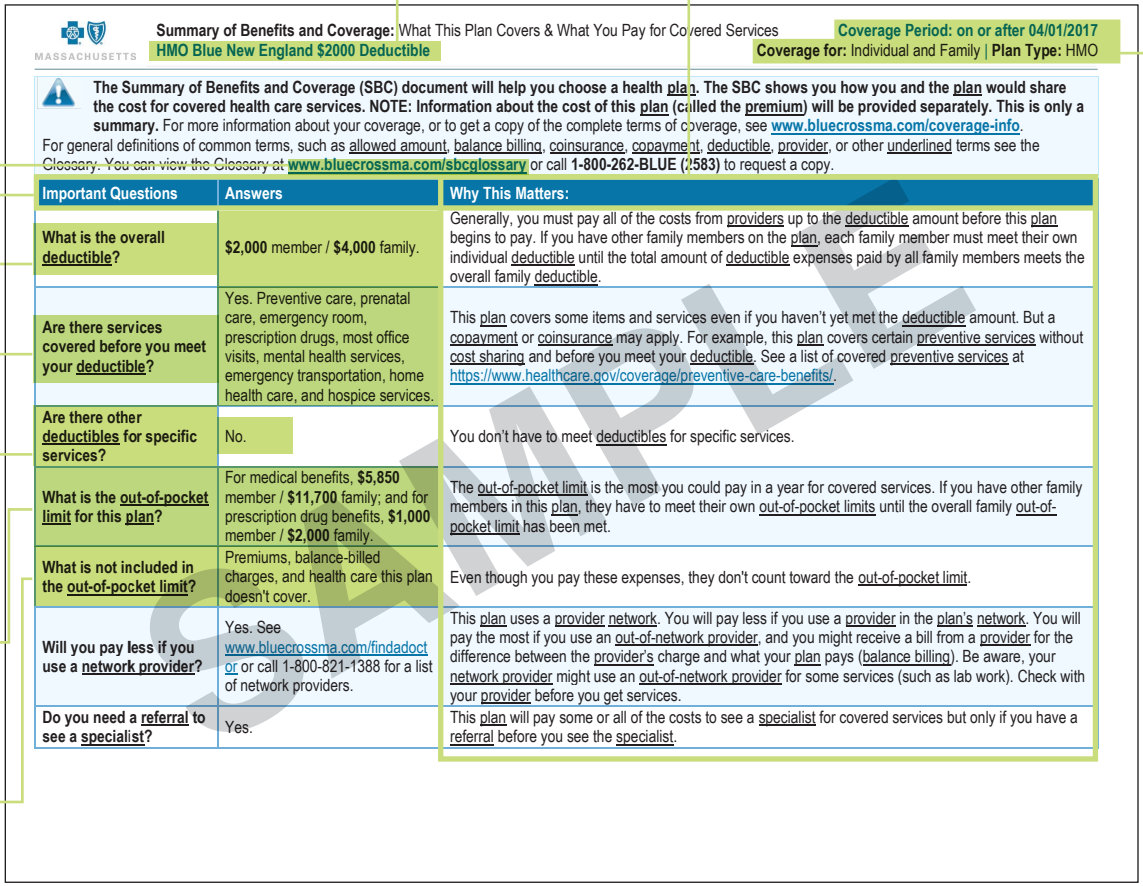
Shows any separate deductible that may apply to a specific benefit category such as inpatient or pharmacy benefits.

Shows the dollar amounts of the plan's out-of-pocket maximums for medical and prescription drug benefits for individual and family.

Shows any major benefit category that is excluded from the out-of-pocket limit calculation (for example, premiums, balanced-billed charges, other).

This is the name of the health plan.

This section provides the reason why this information is important.



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Summary of Benefits and Coverage: What This Plan Covers & What You Pay for Covered Services

HMO Blue New England $2000 Deductible

Coverage Period: on or after 04/01/2017

Coverage for: Individual and Family | **Plan Type:** HMO

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.bluecrossma.com/coverage-info.

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 www.bluecrossma.com/sbcglossary or call **1-800-262-BLUE (2583)** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** member / **$4,000** 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.
Are there services covered before you meet your deductible?	Yes. Preventive care, prenatal care, emergency room, prescription drugs, most office visits, mental health services, emergency transportation, home health care, and hospice services.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, **$5,850** member / **$11,700** 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.
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.
Will you pay less if you use a network provider?	Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 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.
Do you 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 a referral before you see the specialist.

Lists coverage effective dates, who the coverage is for, and plan type.

The type of coverage depends on the plan type:

- **HMO:** references the HMO Blue, HMO Blue New England, Access Blue, and Access Blue New England plans
- **HMO Tiered:** references the Blue Options HMO plans and the plans with a Hospital Choice Cost Sharing (HCCS) benefit feature
- **Managed:** references the Network Blue®, Network Blue® New England, and Access Blue New England ASC plans
- **Managed Tiered:** references the self-insured plans for Blue Options and Network Blue®, Network Blue® New England, and Access Blue New England that include the HCCS benefit feature
- **PPO:** references the Preferred Blue PPO® and Blue Care Elect® plans
- **PPO Tiered:** references the Blue Options PPO plans and the plans with the HCCS benefit feature
- **EPO:** references the Advantage Blue® plans
- **POS:** references the Blue Choice®, Blue Choice® New England, Blue Choice® Plan 2, and Blue Choice® New England Plan 2 plans
- **Indemnity:** references the indemnity plans

For a complete description of benefits, please refer to your subscriber certificate, benefit description, or plan materials.

In this section, a chart is provided to show the cost share, limitations, and pre-authorization requirements associated with common medical events.

The chart is separated into 10 common medical events along with the services, cost share, and limitations and exceptions associated with that event.

This section is separated into the various provider types from whom a member may seek care, including specialists and primary care providers.

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	$25 / visit	Not covered	Cost share waived for the first two diabetic PCP and / or specialist visits per calendar year
	Specialist visit	$40 / visit; $40 / chiropractor visit	Not covered	Cost share waived for the first two diabetic PCP and / or specialist visits per calendar year
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15	Not covered	Deductible applies first; copayment applies per category of test / day
	Imaging (CT/PET scans, MRIs)	$75	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services

Most SBCs will show two levels of costs (in-network and out-of-network). Some plans have additional cost levels such as Tiered network plans like Blue Options or HCCS.

Please note that even though managed care plan designs do not cover out-of-network providers (except for urgent and emergency care), we are required to include this information in the SBC.

Deductible information will be listed in the Limitations & Exceptions column. To find out what the overall deductible is, members should refer to **"What is the overall deductible?"** or **"Are there other deductibles for specific services?"** on page 1 of the SBC.

The Limitations & Exceptions column is where members can find if the deductible applies, if the cost share is waived, if pre-authorization is needed, and if there is a visit or quantity limit for that service.

For a complete description of benefits, please refer to your subscriber certificate, benefit description, or plan materials.

This section includes the prescription drug cost share at retail and mail service pharmacies, and value-based drug benefits if applicable. Please note that each drug segment equals our current tier descriptions.

This website directs members to the Medication Look Up on our website. It provides access to a list of all drugs we cover and details on how they are covered. If your prescription drug coverage is administered by a third party vendor, this website is left blank.

This section shows the cost share for outpatient surgery when performed at an ambulatory surgical facility and not at an office or general hospital.

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 prescription drug coverage is available at www.bluecrossma.com/medications	Generic drugs	$25 / retail supply or $50 ($25 for value drugs) / mail service supply for low-cost generic drugs; $50 / retail supply or $100 ($50 for value drugs) / mail service supply for other generic drugs	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	$75 / retail supply or $150 ($75 for value drugs) / mail service supply	Not covered	
	Non-preferred brand drugs	$150 / retail supply or $450 / mail service supply	Not covered	
	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)	No charge	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 care	$250 / visit	$250 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$40 / visit	$40 / visit	Out-of-network coverage limited to out of service area

Most generic medications are covered and are equal to a Tier 1 or Tier 2 cost depending on your benefit plan.

Most preferred brand-name medications are covered and are equal to a Tier 2 or Tier 3 cost depending on your benefit plan.

Most non-preferred brand-name medications are covered and are equal to a Tier 3 or Tier 4 cost depending on your benefit plan.

For a complete description of benefits, please refer to your subscriber certificate, benefit description, or plan materials.

This section explains the cost share for an inpatient admission at a general hospital.

This section includes cost share and limitations for care related to pregnancy, such as office visits and delivery 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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit	Not covered	Pre-authorization required for certain services
	Inpatient services	No charge	Not covered	Pre-authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first for childbirth/delivery facility services; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

This section outlines the cost share for mental health and substance abuse treatment. For inpatient services, the cost share referenced is for services at a general hospital, mental hospital, or substance abuse treatment facility. For outpatient services, the cost share is in regards to services performed in an office setting.

For a complete description of benefits, please refer to your subscriber certificate, benefit description, or plan materials.

This section includes the cost share and limitations for home health care, rehabilitation and habilitation services, skilled nursing care, durable medical equipment, and hospice services.

This section is specific to benefits for children.

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	Home health care	No charge	Not covered	Pre-authorization required
	Rehabilitation services	$40 / visit	Not covered	Deductible applies first; 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	$40 / visit	Not covered	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); cost share and coverage limits waived for early intervention services for eligible children; pre-authorization may be 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 services	No charge	Not covered	Pre-authorization 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 12 months until the end of the month a member turns age 19
	Children's glasses	35% coinsurance	Not covered	Deductible applies first; limited to one set of prescription lenses and / or frames or contact lenses per calendar year until the end of the month a member turns age 19
	Children's dental check-up	No charge	Not covered	Limited to twice per calendar year until the end of the month a member turns age 19

A habilitation service helps a person to achieve developmental skills and functionality for use in daily life.

Dental is covered on a medical policy in a limited capacity, such as mandated coverage under health care reform.

For a complete description of benefits, please refer to your subscriber certificate, benefit description, or plan materials.

Each SBC will place all of the benefit categories listed in either the "Services Your Plan Does Not Cover" box or the "Other Covered Services" box according to the plan provisions.

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.)

- Acupuncture
- 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.)

- Abortion
- 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 (three months in qualified program(s) per contract per calendar year)

For a complete description of benefits, please refer to your subscriber certificate, benefit description, or plan materials.

Your Rights to Continue Coverage:
If you have Individual health insurance:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 the state marketplace, please contact the Massachusetts Health Connector at www.mahealthconnector.org. For more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583).

OR

If you have Group health 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 x6156 or 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. 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Member Service number listed on your ID card or contact your plan sponsor. (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.mass.gov/hpc/opp.

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

All of our fully insured standard plans meet both minimum essential coverage (MEC) and minimum value standard (MVS). Please note for custom self-insured accounts, if the plan carves out certain benefits to a third-party insurer or administrator, such as mental health or pharmacy benefits, we cannot assess whether the plan meets or does not meet MVS. It is up to the employer to communicate this information to their eligible employees.

This portion of the SBC includes information about certain rights and programs that are accessible to the member, including the rights to continue coverage, and grievance and appeal rights.

The Questions and Answers page is designed to help members understand the coverage examples on the previous page.

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)		**Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Jacquie's Simple Fracture** (in-network emergency room visit and follow-up care)	
■ **The plan's overall deductible**	**$2,000**	■ **The plan's overall deductible**	**$2,000**	■ **The plan's overall deductible**	**$2,000**
■ **Delivery fee copay**	**$0**	■ **Specialist visit copay**	**$40**	■ **Specialist visit copay**	**$40**
■ **Facility fee copay**	**$0**	■ **Primary care visit copay**	**$25**	■ **Emergency room copay**	**$250**
■ **Diagnostic tests copay**	**$15**	■ **Diagnostic tests copay**	**$15**	■ **Ambulance services copay**	**$0**
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits *(prenatal care)*		Primary care physician office visits *(including disease education)*		Emergency room care *(including medical supplies)*	
Childbirth/Delivery Professional Services		Diagnostic tests *(blood work)*		Diagnostic test *(x-ray)*	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment *(crutches)*	
Diagnostic tests *(ultrasounds and blood work)*		Durable medical equipment *(glucose meter)*		Rehabilitation services *(physical therapy)*	
Specialist visit *(anesthesia)*					
Total Example Cost	**$12,713**	**Total Example Cost**	**$7,389**	**Total Example Cost**	**$1,925**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Jacquie would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$2,000	Deductibles	$134	Deductibles	$216
Copayments	$18	Copayments	$1,230	Copayments	$330
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$55	Limits or exclusions	$0
The total Peg would pay is	**$2,078**	**The total Joe would pay is**	**$1,419**	**The total Jacquie would pay is**	**$546**

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

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The deductible includes everything the member pays up to the deductible amount shown on page 1 of the SBC.

Copays are the copayments for services that have a copayment associated with the benefit.

Coinsurance is anything the member pays above the deductible that is not a copay or non-covered service.

Limits or exclusions are anything the member pays for non-covered services or services that exceed plan limits.

These illustrations are provided to show how the plan designs referenced in the SBC might cover medical care in a given situation.

For a complete description of benefits, please refer to your subscriber certificate, benefit description, or plan materials.

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