



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 <http://www.worcesterma.gov/>.

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.com/sbcglossary or call 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other <u>deductibles</u> for specific services?	Yes. For services at a general hospital, \$500 member / \$1,000 family Standard Benefits Tier; \$500 member / \$1,000 family Basic Benefits Tier. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$4,000 member / \$8,000 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.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	You pay the least if you use a <u>provider</u> in enhanced benefits tier. You pay more if you use a <u>provider</u> in standard benefits tier or basic benefits tier. 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</u> charge 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.
Do you need a <u>referral</u> to see a <u>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
		Enhanced Benefits Tier (You will pay the least)	Standard Benefits Tier	Basics Benefits Tier	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	\$30 / visit	\$40 / visit	Not covered	None
	<u>Specialist</u> visit	\$40 / visit; \$40 / chiropractor visit	\$40 / visit; \$40 / chiropractor visit	\$40 / visit; \$40 / chiropractor visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge	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	<u>Diagnostic test</u> (x-ray, blood work)	No charge	No charge	No charge	Not covered	Deductible applies to Standard (except for select hospitals) and Basic Benefits Tier general hospitals; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	\$50	\$50	\$450 for hospitals; \$50 for other providers	Not covered	Deductible applies to Standard (except for select hospitals) and Basic Benefits Tier general hospitals; copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Enhanced Benefits Tier (You will pay the least)	Standard Benefits Tier	Basics Benefits Tier	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 www. .com	Generic drugs					
	Preferred brand drugs					
	Non-preferred brand drugs					
	<u>Specialty drugs</u>					
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 / admission	\$150 / admission (\$200 / admission for select hospitals)	\$500 / admission for hospitals; \$150 / admission for ambulatory surgical facilities	Not covered	Deductible applies to Standard (except for select hospitals) and Basic Benefits Tier general hospitals; pre-authorization required for certain services
	Physician/surgeon fees	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	\$100 / visit	\$100 / visit	Copayment waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	No charge	No charge	None
	<u>Urgent care</u>	\$40 / visit	\$40 / visit	\$40 / visit	\$40 / visit	Out-of-network coverage limited to out of service area

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Enhanced Benefits Tier (You will pay the least)	Standard Benefits Tier	Basics Benefits Tier	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 / admission	\$150 / admission (\$200 / admission for select hospitals)	\$500 / admission	Not covered	Deductible applies to Standard (except for select hospitals) and Basic Benefits Tier general hospitals; pre-authorization required
	Physician/surgeon fees	No charge	No charge	No charge	Not covered	Pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	\$20 / visit	\$20 / visit	Not covered	Pre-authorization required for certain services
	Inpatient services	\$150 / admission	\$200 / admission for general hospitals (\$150 / admission for select hospitals); \$150 / admission for mental hospitals or substance abuse facilities	\$500 / admission for general hospitals; \$150 / admission for mental hospitals or substance abuse facilities	Not covered	Deductible applies to Standard (except for select hospitals) and Basic Benefits Tier general hospitals; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	No charge	No charge	Not covered	Deductible applies to childbirth/delivery facility services for Standard (except for select hospitals) and Basic Benefits Tier general hospitals; 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	No charge	No charge	Not covered	
	Childbirth/delivery facility services	\$150 / admission	\$150 / admission (\$200 / admission for select hospitals)	\$500 / admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Enhanced Benefits Tier (You will pay the least)	Standard Benefits Tier	Basics Benefits Tier	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	No charge	No charge	Not covered	Pre-authorization required
	<u>Rehabilitation services</u>	\$40 / visit	\$40 / visit	\$40 / 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
	<u>Habilitation services</u>	\$40 / visit	\$40 / visit	\$40 / 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
	<u>Skilled nursing care</u>	No charge	No charge	No charge	Not covered	Limited to 100 days per calendar year; pre-authorization required
	<u>Durable medical equipment</u>	20% coinsurance	20% coinsurance	20% coinsurance	Not covered	Cost share waived for one breast pump per birth
	<u>Hospice services</u>	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	No charge for members with a cleft palate / cleft lip condition	No charge for members with a cleft palate / cleft lip condition	Not covered	Limited to members under age 18

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
- 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.)

- 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.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.)

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? [No]

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	\$0
■ Delivery fee copay	\$0
■ Facility fee copay	\$150
■ 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	\$12,713
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In this example, Peg would pay:

Cost Sharing

Deductibles*	\$500
Copayments	\$150
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$78
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The total Peg would pay is	\$728
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist visit copay	\$40
■ Primary care visit copay	\$30
■ 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	\$7,389
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$260
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$6,041
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The total Joe would pay is	\$6,301
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Jacque's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist visit copay	\$40
■ 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	\$1,925
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In this example, Jacque would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$300
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Jacque would pay is	\$300
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*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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