



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 <http://www.worcesterma.gov> or by calling 1-800-932-8323.

| Important Questions | Answers | Why this Matters: |
|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible? | \$0 | See the chart starting on page 2 for your costs for services this plan covers. |
| Are there other deductibles 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 deductible amount before this plan begins to pay for these services. |
| Is there an out-of-pocket limit on my expenses? | Yes. \$4,000 member / \$8,000 family for medical services; \$1,500 member / \$3,000 family for prescription drugs. | 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 8. 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 enhanced benefits tier **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 |
|---------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|----------------|------------------------------------------------|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 / visit | \$30 / visit | \$40 / visit | Not covered | — none — |
| | Specialist visit | \$40 / visit | \$40 / visit | \$40 / visit | Not covered | — none — |
| | Other practitioner office visit | \$40 / chiropractor visit; \$25 / chiropractor visit in Maine | \$40 / chiropractor visit; \$25 / chiropractor visit in Maine | \$40 / chiropractor visit; \$25 / chiropractor visit in Maine | Not covered | — none — |
| | Preventive care/screening/immunization | No charge | No charge | No charge | Not covered | GYN exam limited to one exam per calendar year |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|----------------------|-------------------------------------|------------------------|------------------------|----------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | No charge | No charge | Not covered | Deductible applies to Standard (except for selected hospitals) and Basic Benefits Tier general hospitals |
| | Imaging (CT/PET scans, MRIs) | \$50 | \$50 | \$50 (\$450 for hospitals) | Not covered | Deductible applies to Standard (except for selected 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 | Your cost if you use | | | | Limitations & Exceptions |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.caremark.com.</p> | Tier 1 plus Mail Order | \$10 copay/prescription (retail and emergency); \$20 copay/prescription (mail order) | \$10 copay/prescription (retail and emergency); \$20 copay/prescription (mail order) | \$10 copay/prescription (retail and emergency); \$20 copay/prescription (mail order) | \$10 copay/prescription (emergency only) | Members will receive the first two <u>Maintenance Medication</u> fills through their pharmacy, and then will be required to change to a 90-day refill schedule through their local CVS pharmacy or CVS mail order. |
| | Tier 2 plus Mail Order | \$25 copay/prescription (retail and emergency); \$50 copay/prescription (mail order) | \$25 copay/prescription (retail and emergency); \$50 copay/prescription (mail order) | \$25 copay/prescription (retail and emergency); \$50 copay/prescription (mail order) | (\$25 copay/prescription (emergency only)) | Members will receive the first two <u>Maintenance Medication</u> fills through their pharmacy, and then will be required to change to a 90-day refill schedule through their local CVS pharmacy or CVS mail order. |
| | Tier 3 plus Mail Order | \$50 copay/prescription (retail and emergency); \$150 copay/prescription (mail order) | \$50 copay/prescription (retail and emergency); \$150 copay/prescription (mail order) | \$50 copay/prescription (retail and emergency); \$150 copay/prescription (mail order) | (\$50 copay/prescription (emergency only)) | Members will receive the first two <u>Maintenance Medication</u> fills through their pharmacy, and then will be required to change to a 90-day refill schedule through their local CVS pharmacy or CVS mail order. |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|-----------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| | Specialty drugs | Copay of \$10, \$25, or \$50 per prescription based on drug tier (see tiers above) when purchased at a retail or designated specialty pharmacy | Copay of \$10, \$25, or \$50 per prescription based on drug tier (see tiers above) when purchased at a retail or designated specialty pharmacy | Copay of \$10, \$25, or \$50 per prescription based on drug tier (see tiers above) when purchased at a retail or designated specialty pharmacy | Copay of \$10, \$25, or \$50 / prescription (emergency only) | Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply. Some drugs may only be filled at the CVS/caremark Specialty Pharmacy. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$150 / admission | \$150 / admission (\$200 for selected hospitals) | \$500 / admission | Not covered | Deductible applies to Standard (except for selected 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 | Emergency room services | \$100 / visit | \$100 / visit | \$100 / visit | \$100 / visit | Copayment waived if admitted or for observation stay |
| | Emergency medical transportation | No charge | No charge | No charge | No charge | — none — |
| | Urgent care | \$40 / visit | \$40 / visit | \$40 / visit | \$40 / visit | Out-of-network coverage limited to out of service area |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$150 / admission | \$150 / admission (\$200 for selected hospitals) | \$500 / admission | Not covered | Deductible applies to Standard (except for selected hospitals) and Basic Benefits Tier general hospitals; pre-authorization required |
| | Physician/surgeon fee | No charge | No charge | No charge | Not covered | Pre-authorization required |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|-------------------------------------------------------------------------------|----------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$20 / visit | \$20 / visit | \$20 / visit | Not covered | Pre-authorization required for certain services |
| | Mental/Behavioral health inpatient services | \$150 / admission | \$150 / admission for mental hospitals or substance abuse facilities; \$150 / admission for general hospitals (\$200 for selected hospitals) | \$150 / admission for mental hospitals or substance abuse facilities; \$500 / admission for general hospitals | Not covered | Deductible applies to Standard (except for selected hospitals) and Basic Benefits Tier general hospitals; pre-authorization required |
| | Substance use disorder outpatient services | \$20 / visit | \$20 / visit | \$20 / visit | Not covered | Pre-authorization required for certain services |
| | Substance use disorder inpatient services | \$150 / admission | \$150 / admission for mental hospitals or substance abuse facilities; \$150 / admission for general hospitals (\$200 for selected hospitals) | \$150 / admission for mental hospitals or substance abuse facilities; \$500 / admission for general hospitals | Not covered | Deductible applies to Standard (except for selected hospitals) and Basic Benefits Tier general hospitals; pre-authorization required |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|----------------------------------------------------------------|-------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| If you are pregnant | Prenatal and postnatal care | No charge | No charge | No charge | Not covered | — none — |
| | Delivery and all inpatient services | \$150 / admission and no charge for delivery | \$150 / admission (\$200 for selected hospitals) and no charge for delivery | \$500 / admission and no charge for delivery | Not covered | Deductible applies to Standard (except for selected hospitals) and Basic Benefits Tier general hospitals |
| If you need help recovering or have other special health needs | Home health care | No charge | No charge | No charge | Not covered | Pre-authorization required |
| | Rehabilitation services | \$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 |
| | Habilitation services | \$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 |
| | Skilled nursing care | No charge | No charge | No charge | Not covered | Limited to 100 days per calendar year; pre-authorization required |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | 20% coinsurance | Not covered | Cost share waived for one breast pump per birth |
| | Hospice service | No charge | No charge | No charge | Not covered | Pre-authorization required for certain services |

| Common Medical Event | Services You May Need | Your cost if you use | | | | Limitations & Exceptions |
|----------------------------------------|-----------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|----------------|-------------------------------------|
| | | Enhanced Benefits Tier | Standard Benefits Tier | Basic Benefits Tier | Out-of-Network | |
| If your child needs dental or eye care | Eye exam | No charge | No charge | No charge | Not covered | Limited to one exam every 24 months |
| | Glasses | Not covered | Not covered | Not covered | Not covered | — none — |
| | 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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- 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:

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 not 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 hodiilné t'áá jííkeh béesh bee' hane'jí T'áá doolé'é bina'íshdiłkidgo yeeháká'adooljah éí binumber bee néého'dolzin biniyé 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 \$6,720
- Patient pays \$820

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 | \$500 |
| Copays | \$150 |
| Coinsurance | \$0 |
| Limits or exclusions | \$170 |
| Total | \$820 |

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

- Amount owed to providers: \$5,400
- Plan pays \$920
- Patient pays \$4,480

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 | \$280 |
| Coinsurance | \$0 |
| Limits or exclusions | \$4,200 |
| Total | \$4,480 |

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 standard benefits tier providers. If the patient had received care from other in-network or out-of-network providers, costs would have been different.

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.