

BLUE CARE ELECT PREFERRED

WITH HOSPITAL CHOICE COST SHARING

MIIA Town of Ipswich

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



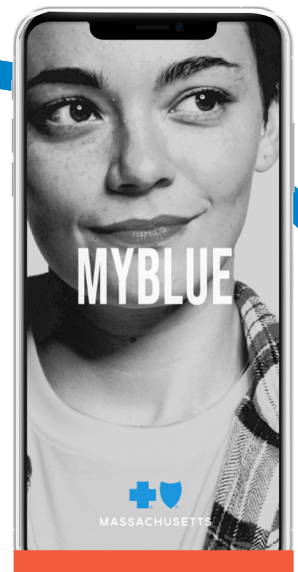
CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

Download the app, or create an account at bluecrossma.org.



Where you get care can impact what you pay for care.

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/or 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 any of the preferred general hospitals listed in this Summary of Benefits, 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 (not listed in this Summary of Benefits 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 bluecrossma.org/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.



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.

YOUR CHOICE

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your “in-network” benefits. See the charts for your cost share.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive inpatient services at or by “higher cost share hospitals,” even if your preferred provider refers you. See the chart for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

Higher Cost Share Hospitals

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- **Baystate Medical Center**
- **Boston Children's Hospital**
- **Brigham and Women's Hospital**
- **Cape Cod Hospital**
- **Dana-Farber Cancer Institute**
- **Fairview Hospital**
- **Massachusetts General Hospital**
- **UMass Memorial Medical Center**

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost share may apply.

How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider on Find a Doctor at bluecrossma.com/findadoctor. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your “out-of-network” benefits. See the charts for your cost share.

You must pay a plan-year deductible before you can receive coverage for most out-of-network benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$400** per member (or **\$800** per family).

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$2,500** per member (or **\$5,000** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org, consult Find a Doctor, or call the Member Service number on your ID card.

Utilization Review Requirements

Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

Value Care Offering Coverage

Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

| Covered Services | Your Cost In-Network | Your Cost Out-of-Network |
|---|---|--|
| Preventive Care | | |
| Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older | Nothing | 20% coinsurance after deductible |
| Routine adult physical exams, including related tests (one per calendar year) | Nothing | 20% coinsurance after deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | Nothing | 20% coinsurance after deductible |
| Routine hearing exams, including routine tests | Nothing | 20% coinsurance after deductible |
| Hearing aids (up to \$5,000 per ear every 36 months) | All charges beyond the maximum | 20% coinsurance after deductible and all charges beyond the maximum |
| Routine vision exams (one every 24 months) | Nothing | 20% coinsurance after deductible |
| Family planning services—office visits | Nothing | 20% coinsurance after deductible |
| Outpatient Care | | |
| Emergency room visits | \$100 per visit (waived if admitted or for an observation stay) | \$100 per visit, no deductible (waived if admitted or for an observation stay) |
| Office or health center visits, when performed by: <ul style="list-style-type: none"> • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, licensed dietitian nutritionist, optometrist, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | \$20 per visit \$35 per visit | 20% coinsurance after deductible 20% coinsurance after deductible |
| Mental health or substance use treatment | \$15 per visit | 20% coinsurance after deductible |
| Outpatient telehealth services <ul style="list-style-type: none"> • With a covered provider • With the designated telehealth vendor for simple medical conditions • With the designated telehealth vendor for mental health services | Same as in-person visit \$20 per visit \$15 per visit | Same as in-person visit Not applicable Not applicable |
| Chiropractors' office visits (up to 20 visits per calendar year) | \$20 per visit | 20% coinsurance after deductible |
| Acupuncture visits (up to 12 visits per calendar year) | \$35 per visit | 20% coinsurance after deductible |
| Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year for each type of therapy*) | \$20 per visit | 20% coinsurance after deductible |
| Speech, hearing, and language disorder treatment—speech therapy | \$20 per visit | 20% coinsurance after deductible |
| Diagnostic X-rays and lab tests | Nothing | 20% coinsurance after deductible |
| CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | \$100 per category per service date | 20% coinsurance after deductible |
| Home health care and hospice services | Nothing | 20% coinsurance after deductible |
| Oxygen and equipment for its administration | Nothing | 20% coinsurance after deductible |
| Durable medical equipment—such as wheelchairs, crutches, hospital beds | Nothing | 20% coinsurance after deductible |
| Prosthetic devices | Nothing | 20% coinsurance after deductible |
| Surgery and related anesthesia in an office or health center, when performed by: <ul style="list-style-type: none"> • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care | \$20 per visit** \$35 per visit** | 20% coinsurance after deductible 20% coinsurance after deductible |
| Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit | \$150 per admission | 20% coinsurance after deductible |
| Inpatient Care (including maternity care) in: | | |
| <ul style="list-style-type: none"> • Other general hospitals (as many days as medically necessary) • Higher cost share hospitals (as many days as medically necessary) | \$300 per admission† \$700 per admission† | 20% coinsurance after deductible 20% coinsurance after deductible |
| Chronic disease hospital care (as many days as medically necessary) | Nothing | 20% coinsurance after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | \$200 per admission | 20% coinsurance after deductible |
| Rehabilitation hospital care (as many days as medically necessary) | Nothing | 20% coinsurance after deductible |
| Skilled nursing facility care (up to 45 days per calendar year) | Nothing | 20% coinsurance after deductible |

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

† This cost share applies to mental health admissions in a general hospital.

| Covered Services | Your Cost In-Network | Your Cost Out-of-Network |
|---|---|--------------------------|
| Prescription Drug Benefits* | | |
| At designated retail pharmacies** (up to a 30-day formulary supply for each prescription or refill)*** | \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3 | Not covered |
| Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)*** | \$20 for Tier 1† \$50 for Tier 2 \$110 for Tier 3 | Not covered |

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.

** Specialty drugs available only when obtained from a designated specialty pharmacy.

*** Cost share may be waived for certain covered drugs and supplies.

† Certain generic medications are available through the mail order pharmacy at \$9. For more information, go to bluecrossma.org/mail-order-pharmacy.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program

Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)

\$300 per calendar year per policy

Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)

\$300 per calendar year per policy

 **24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.**

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

® Registered Marks of the Blue Cross and Blue Shield Association. © 2022 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. Printed at Blue Cross and Blue Shield of Massachusetts, Inc.

001489264 (3/22) JB

Left Blank Intentionally



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.emiia.com. 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: |
|--|--|---|
| What is the overall deductible? | \$0 in-network; \$400 member / \$800 family out-of-network. | 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> . |
| Are there services covered before you meet your deductible? | Yes. Emergency room and emergency transportation. | 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/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | For medical benefits, \$2,500 member / \$5,000 family; and for <u>prescription drug</u> benefits, \$1,000 member / \$2,000 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 out-of-pocket limit? | <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> . |
| Will you pay less if you use a network provider? | 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. |
| Do you need a referral to see a specialist? | No. | You can see the <u>specialist</u> you choose without a <u>referral</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 | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric <u>specialist</u> , nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care; a telehealth <u>cost share</u> may be applicable |
| | <u>Specialist</u> visit | \$35 / visit; \$20 / chiropractor visit; \$35 / acupuncture visit | 20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit | <u>Deductible</u> applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 20 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable |
| | <u>Preventive care/screening/immunization</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; 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. |

| 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 test | Diagnostic test (x-ray, blood work) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> may be required |
| | Imaging (CT/PET scans, MRIs) | \$100 | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> may be required |
| 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 \$20 / designated retail or mail order supply | Not covered | Up to 30-day retail (90-day designated retail or mail order) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs |
| | Preferred brand drugs | \$25 / retail supply or \$50 / designated retail or mail order supply | Not covered | |
| | Non-preferred brand drugs | \$50 / retail supply or \$110 / designated retail or mail order 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>pre-authorization</u> required for certain drugs |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$150 / admission | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required for certain services |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <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 immediate medical attention | <u>Emergency room care</u> | \$100 / visit | \$100 / visit; deductible does not apply | <u>Copayment</u> waived if admitted or for observation stay |
| | <u>Emergency medical transportation</u> | No charge | No charge | None |
| | <u>Urgent care</u> | \$35 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$300 / admission; \$700 / admission for certain hospitals | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$15 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>cost share</u> may be waived or reduced for certain services; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | Inpatient services | \$200 / admission for mental hospitals or substance abuse facilities; \$300 / admission for general hospitals; \$700 / admission for certain hospitals | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required for certain services |
| If you are pregnant | Office visits | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>cost sharing</u> does not apply for in-network <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 | 20% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | \$300 / admission; \$700 / admission for certain hospitals | 20% <u>coinsurance</u> | |

| 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 | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required |
| | <u>Rehabilitation services</u> | \$20 / visit for outpatient services; No charge for inpatient services | 20% <u>coinsurance</u> for outpatient services; 20% <u>coinsurance</u> for inpatient services | <u>Deductible</u> applies first for out-of-network; limited to 30 outpatient visits per type of therapy per calendar year (other than for autism, <u>home health care</u> , and speech therapy); a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | <u>Habilitation services</u> | \$20 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; 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>Skilled nursing care</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to 45 days per calendar year; <u>pre-authorization</u> required |
| | <u>Durable medical equipment</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; in-network <u>cost share</u> waived for one breast pump per birth |
| | <u>Hospice services</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required for certain services |
| If your child needs dental or eye care | Children's eye exam | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to one exam every 24 months |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | No charge for members with a cleft palate / cleft lip condition | 20% <u>coinsurance</u> for members with a cleft palate / cleft lip condition | <u>Deductible</u> applies first for out-of-network; 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.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none">• Children's glasses• Cosmetic surgery | <ul style="list-style-type: none">• Dental care (Adult)• Long-term care | <ul style="list-style-type: none">• Private-duty nursing |
|---|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none">• Acupuncture (12 visits per calendar year)• Bariatric surgery• Chiropractic care (20 visits per calendar year)• Hearing aids (\$5,000 per ear every 36 months) | <ul style="list-style-type: none">• Infertility treatment• Non-emergency care when traveling outside the U.S.• Routine eye care - adult (one exam every 24 months) | <ul style="list-style-type: none">• Routine foot care (only for patients with systemic circulatory disease)• Weight loss programs (\$300 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 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)

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <u>Delivery fee copay</u> | \$0 |
| ■ <u>Facility fee copay</u> | \$300 |
| ■ <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 |
|---------------------------|-----------------|

In this example, Peg would pay:

Cost Sharing

| | |
|--------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$300 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|--------------|
| The total Peg would pay is | \$360 |
|-----------------------------------|--------------|

Managing Joe's Type 2 Diabetes

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

| | |
|---|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <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 |
|---------------------------|----------------|

In this example, Joe would pay:

Cost Sharing

| | |
|--------------------|---------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$1,100 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$1,120 |
|-----------------------------------|----------------|

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <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 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|--------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Mia would pay is | \$200 |
|-----------------------------------|--------------|

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

* Registered Marks of the Blue Cross and Blue Shield Association. © 2022 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

001489247 (3/22) JB



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.



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 bluecrossma.org/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.

Left Blank Intentionally