



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.ci.fitchburg.ma.us. 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 1-800-932-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$250 member / \$750 family.	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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive care</u> , prenatal care, <u>prescription drugs</u> , most office visits, mental health services, therapy visits, emergency transportation, <u>home health care</u> , and <u>hospice services</u> .	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 cost sharing 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/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	\$1,500 member / \$3,000 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.
<u>What is not included in the out-of-pocket limit?</u>	<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> .
<u>Will you pay less if you use a network provider?</u>	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.
<u>Do you need a referral to see a 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
		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	Not covered	A telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$40 / visit; \$40 / chiropractor visit; \$40 / acupuncture visit	Not covered	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	Not covered	GYN exam limited to one exam per calendar year; 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$50	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <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 drugs to treat your illness or condition More information about prescription drug coverage is available at bluecrossma.org/medication	Generic drugs	\$15 / retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; <u>cost share</u> may be waived or reduced for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$30 / retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$50 / retail or mail service 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>cost share</u> may be waived or reduced for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit	\$150 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$40 / visit	\$40 / visit	Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable

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)	\$500 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$500 / admission	Not covered	<u>Pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	<u>Deductible</u> applies first for childbirth/delivery facility services; <u>cost sharing</u> does not apply for <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	Not covered	
	Childbirth/delivery facility services	\$500 / admission	Not covered	

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	Not covered	<u>Pre-authorization</u> required
	<u>Rehabilitation services</u>	\$40 / visit for outpatient services; No charge for inpatient services	Not covered	<u>Deductible</u> applies first except for outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a <u>telehealth cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$40 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a <u>telehealth cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	No charge	Not covered	<u>Pre-authorization</u> 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 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

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.)

• Children's glasses	• Long-term care	• Private-duty nursing
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	
• Dental care (Adult)		

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

• Acupuncture (12 visits per calendar year)	• Infertility treatment	• Weight loss programs (\$150 per calendar year per policy)
• Bariatric surgery	• Routine eye care - adult (one exam every 24 months)	
• Chiropractic care	• Routine foot care (only for patients with systemic circulatory disease)	
• Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)		

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 1-800-932-8323 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)

■ <u>The plan's overall deductible</u>	\$250
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$500
■ <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
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$810

Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$250
■ <u>Specialist visit copay</u>	\$40
■ <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
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$250
■ <u>Specialist visit copay</u>	\$40
■ <u>Emergency room copay</u>	\$150
■ <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
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$650

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

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MASSACHUSETTS

MCC COMPLIANCE



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.



MASSACHUSETTS

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, 25 Technology Place, Hingham, MA 02043; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at civilrightscoordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at ocrportal.hhs.gov; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at hhs.gov.

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部 (TTY 号码: **711**)。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifikasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телефон: **711**).

Arabic/عَرَبِيَّة:

انتبه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النبوي للصم والبكم "TTY" : **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការដែនដំណឹង៖ ប្រសិនបើអ្នកនឹងយាយភាសា ខ្មែរ សេវាដំនឹងយាយភាសាតំនើត តើអាជរការណ៍សម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្ទៀកសេវាសមាជិកតាមលេខទ័រលេខបណ្តុះសម្រាប់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निःशल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કોલ કરો (TTY: 711).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: 711).

Japanese/日本語: お知らせ:日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください (TTY: 711)。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: 711).

Persian/پارسیان:

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

Lao/ລາວ: ຂໍ້ຄວນໄຟ້ໄຈ: ຖ້າຈົ່າເວົ້າພາວາວໄດ້, ມີການບໍລິການຈ່ວຍເຫຼືອດ້ານພາວາໃຫ້ທ່ານໂດຍ ບໍ່ແລ້ວຄ່າ. ໂທ້າຝ່າຍບໍລິການນະມາຊີກທີ່ໝາຍເວັກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áajíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíijí' béishee bee hodíílnih (TTY: 711).