The Guide to Your Summary of Benefits and Coverage (SBC)

Under the federal Affordable Care Act (ACA), health insurers and group health plans are required to provide an SBC. This regulation is intended to give members clear and consistent information about their health plan and a glossary of common health care terms, helping them better understand and evaluate their choices. Blue Cross Blue Shield of Massachusetts will provide an SBC to self-funded and fully insured accounts and direct-pay members upon renewal, application, request, and when material changes occur, at no additional charge. The SBC will only include a description of benefits that we insure or administer, and not a description of benefits that accounts delegate to another third-party insurer or administrator. The SBC is only a summary of benefits and coverage and does not replace the Evidence of Coverage (EOC), subscriber certificate, or plan description that details the full terms of the subscriber coverage. We will continue to provide the EOC to our insured account subscribers.

This guide gives an overview of the Summary of Benefits and Coverage (SBC) format and the information it contains, such as:

- A description of coverage
- Examples of coverage
- Appeals and grievance rights
- Minimum essential coverage and minimum value standard information
- Exceptions and limitations
- Cost share provisions, such as deductible, coinsurance, and copayments

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Health plan name

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

For plans with an overall medical deductible, this section explains the dollar limits of the deductible for individual and family and the major covered benefit categories that the deductible does not apply to.

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

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

HMO Blue New England $1000 Deductible

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: on or after 01/01/2014

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

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 www.bluecrossma.com or by calling **1-800-262-BLUE (2583)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** member / **$2,000** family. Does not apply to preventive care, prenatal care, emergency room, prescription drugs, most office visits, mental health services, emergency transportation, home health care, and hospice services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For medical benefits, **$5,350** member / **$10,700** family; and for prescription drug benefits, **$1,000** member / **$2,000** family.	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 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-262-BLUE (2583)** 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 **1-800-262-BLUE (2583)** to request a copy.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

1 of 9

EXAMPLE

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

The type of coverage depends on the plan design:

- **HMO:** references the HMO Blue®, HMO Blue New England℠, Access Blue℠, and Access Blue New England plan designs
- **HMO Tiered:** references the Blue Options managed care plan designs, the plans with a Hospital Choice Cost Sharing (HCCS) benefit feature, and Essential Blue Young Adult plan designs
- **Managed:** references the Network Blue, Network Blue New England, and Access Blue New England ASC plan designs
- **Managed Tiered:** references the Network Blue®, Network Blue New England, and Access Blue New England ASC plan designs that include the HCCS benefit feature
- **PPO:** references the Preferred Blue PPO℠ and Blue Care Elect℠ plan designs
- **PPO Tiered:** references the Blue Options PPO plan designs and the plans with the HCCS benefit feature
- **EPO:** references the Advantage Blue® plan design
- **POS:** references the Blue Choice®, Blue Choice New England℠, Blue Choice Plan 2, and Blue Choice New England Plan 2 plan designs
- **Indemnity:** references the indemnity plan designs

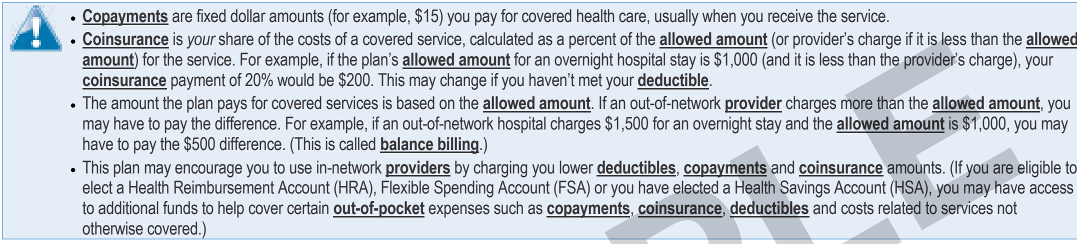
For a complete description of benefits, please refer to your subscriber certificate, benefit description, or plan materials.

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

- Common Medical Events
- Services You May Need
- Your Costs if you use
- Limitations & Exceptions

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

Please note that the other practitioner office visit category refers to chiropractor office visits or acupuncture visits only.



- **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 **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
		In-Network	Out-of-Network	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	Cost share waived for the first two diabetic PCP and / or specialist visits per calendar year
	Specialist visit	$35 / visit	Not covered	Cost share waived for the first two diabetic PCP and / or specialist visits per calendar year
	Other practitioner office visit	$35 / chiropractor visit	Not covered	—— none ——
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services

EXAMPLE

Members can find definitions of key health insurance terms.

Most SBCs will show two levels of costs (in-network and out-of-network). Some plans (for example, plans with tiered networks or plans with the HCCS benefit feature) have additional cost levels. Please note that even though managed care plan designs do not cover out-of-network providers (except for urgent and emergency care), we are required to include this information in the SBC.

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

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

This section includes the prescription drug cost share at retail and mail service pharmacies. Please note that each drug segment equals our current tier descriptions.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com.	Generic drugs	$20 / retail supply or $40 ($20 for value drugs) / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share waived for birth control, smoking cessation and certain orally-administered anticancer drugs; pre-authorization required for certain drugs
	Preferred brand drugs	$40 / retail supply or $80 ($40 for value drugs) / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share waived for smoking cessation and certain orally-administered anticancer drugs; pre-authorization required for certain drugs
	Non-preferred brand drugs	$60 / retail supply or $180 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share waived for certain orally-administered anticancer drugs; pre-authorization required for certain drugs
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room services	$150 / visit	$150 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	—— none ——
	Urgent care	$35 / visit	$35 / visit	Out-of-network coverage limited to out of service area

EXAMPLE

Most generic medications are covered and are equal to a Tier 1 cost.

Most preferred brand-name medications are covered and are equal to a Tier 2 cost.

Most non-preferred brand-name medications are covered and are equal to a Tier 3 cost.

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

This section includes cost share and limitations for care related to pregnancy, such as prenatal, postnatal, delivery, and inpatient services. Please note that if the cost share for prenatal care is different than the cost share for postnatal care, it will be reflected in the cost sharing column as well as the limitations and expectations column.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fee	No charge	Not covered	Deductible applies first; pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Mental/Behavioral health inpatient services	No charge	Not covered	Pre-authorization required
	Substance use disorder outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Substance use disorder inpatient services	No charge	Not covered	Pre-authorization required
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	—— none ——
	Delivery and all inpatient services	No charge	Not covered	Deductible applies first

EXAMPLE

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

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

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-authorization required
	Rehabilitation services	$35 / visit	Not covered	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services
	Habilitation services	$35 / visit	Not covered	Deductible applies first; 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	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Deductible applies first; cost share waived for one breast pump per birth
	Hospice service	No charge	Not covered	Pre-authorization required for certain services
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every 24 months
	Glasses	Not covered	Not covered	—— none ——
	Dental check-up	No charge	Not covered	Limited to members under age 19, twice in 12 months

EXAMPLE

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

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

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

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

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

Your Rights to Continue Coverage:

If you have Individual health insurance:
Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, You can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583). You may also contact your state insurance department at www.mass.gov/doi.

OR

If you have Group health 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 covere 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.

EXAMPLE

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

These two questions are new for 2014 per the ACA. As of July 31, 2013, all of our plans meet both minimum essential coverage (MEC) and minimum value standard (MVS). Please note for custom self-insured accounts, if the plan carves out certain benefits to a third-party insurer or administrator, such as mental health or pharmacy benefits, we cannot assess whether the plan meets or does not meet MVS. It is up to the employer to communicate this information to their eligible associates.

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. You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp.

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 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'ehji shika' a'dowol ninizingo, kwoji hodiilnė t'áá jiikeh béésh bee' hane'ji T'áá doolé'é bina'ishdilkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinigii 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.

EXAMPLE

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

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

The "Patient Pays" sections of these examples provide the dollar amount that each member would pay based on the sample data included in the scenarios.

The deductible includes everything the member pays up to the deductible amount.

Copays are the copayments that do not apply to the deductible.

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

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

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** $6,370
- **Patient pays** $1,170

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	$1,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,170**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,990
- **Patient pays** $1,410

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	$140
Copays	$1,190
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,410**

EXAMPLE

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

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

®, SM Registered Marks and Service Marks of the Blue Cross and Blue Shield Association. © 2013 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
130686 (9/13)