**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see http://www.hampshirecog.org/programs-and-services/insurance-trust. 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 www.bluecrossma.com/sbcglossary or call **1-800-932-8323** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Not applicable. | This plan does not have an overall deductible. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$6,450** member / **$12,900** family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **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. |
| **Will you pay less if you use a network provider?** | Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you 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 a referral before you see the specialist. |

| 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 | $15 / visit | Not covered | None |
| | Specialist visit | $15 / visit; $15 / chiropractor visit | Not covered | None |
| | Preventive care/screening/immunization | No charge | Not covered | GYN exam limited to one exam per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | Pre-authorization required for certain services |
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications** | Generic drugs | $10 / retail supply or $20 / mail service supply | Not covered | Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs |
| | Preferred brand drugs | $25 / retail supply or $50 / mail service supply | Not covered | |
| | Non-preferred brand drugs | $45 / retail supply or $90 / mail service supply | Not covered | |
| | 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 | Pre-authorization required for certain services |
| | Physician/surgeon fees | No charge | Not covered | Pre-authorization 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** | Emergency room care | $75 / visit | $75 / visit | Copayment waived if admitted or for observation stay |
| | Emergency medical transportation | No charge | No charge | None |
| | Urgent care | $15 / visit | $15 / visit | Out-of-network coverage limited to out of service area |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | Not covered | Pre-authorization required |
| | Physician/surgeon fees | No charge | Not covered | Pre-authorization required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 / visit | Not covered | Pre-authorization required for certain services |
| | Inpatient services | No charge | Not covered | Pre-authorization required for certain services |
| **If you are pregnant** | Office visits | No charge | Not covered | Cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | No charge | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Pre-authorization required |
| | Rehabilitation services | $15 / 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 | $15 / 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 | Not covered | Limited to 100 days per calendar year; pre-authorization required |
| | Durable medical equipment | 20% coinsurance | Not covered | Cost share waived for one breast pump per birth |

| 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) | |
| | Hospice services | No charge | Not covered | Pre-authorization 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.)**

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

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

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

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x6156 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Member Service number listed on your ID card or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Does this plan provide Minimum Essential Coverage?** **[Yes]**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards?** **[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 plan's overall deductible | $0 |
| Delivery fee copay | $0 |
| Facility fee copay | $0 |
| Diagnostic tests copay | $0 |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | **$12,713** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $16 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$76** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist visit copay | $15 |
| Primary care visit copay | $15 |
| Diagnostic tests copay | $0 |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$7,389** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,409 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,464** |

### Jacquie's Simple Fracture
(in-network emergency room visit and follow-up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist visit copay | $15 |
| Emergency room copay | $75 |
| Ambulance services copay | $0 |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | **$1,925** |

**In this example, Jacquie would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $150 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Jacquie would pay is** | **$150** |

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