



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.bluecrossma.com/coverage-info. 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 1-888-753-6615 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$150 in-network; \$300 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.
Are there services covered before you meet your <u>deductible</u>?	Yes. In-network preventive and prenatal care, most office visits, therapy visits, mental health visits, prescription drugs, inpatient admissions; emergency room, 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$5,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, and health care this plan 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 <u>network provider</u>?	Yes. See www.bluecrossma.com/findadoct or call 1-800-821-1388 for a list of network providers.	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 <u>referral</u> to see a <u>specialist</u>?	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	\$30 / visit	20% coinsurance	Deductible applies first for out-of-network
	<u>Specialist</u> visit	\$30 / visit	20% coinsurance	Deductible applies first for out-of-network
	<u>Preventive care/screening/immunization</u>	No charge	20% coinsurance	Deductible applies first for out-of-network; 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	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance	30% coinsurance	Deductible applies first
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Deductible applies first; pre-authorization may be required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bluecrossma.com/medications	Generic drugs	\$15 / retail supply or \$35 / 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	\$35 / retail supply or \$85 / mail service supply	Not covered	
	Non-preferred brand drugs	\$60 / retail supply or \$150 / mail service supply	Not covered	
	<u>Specialty drugs</u>	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)	10% coinsurance	30% coinsurance	Deductible applies first
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Deductible applies first

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>	\$150 / visit	\$150 / visit	Copayment waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	10% coinsurance	10% coinsurance	None
	<u>Urgent care</u>	\$30 / visit	20% coinsurance	Deductible applies first for out-of-network
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission, then 10% coinsurance	30% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Physician/surgeon fees	No charge	30% coinsurance	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / visit	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Inpatient services	\$250 / admission, then 10% coinsurance	30% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If you are pregnant	Office visits	No charge for prenatal care; 10% coinsurance for postnatal care	20% coinsurance for prenatal care; 30% coinsurance for postnatal care	Deductible applies first except for in-network prenatal care and childbirth/delivery facility services; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	\$250 / admission, then 10% coinsurance	30% coinsurance	

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>	10% coinsurance	30% coinsurance	Deductible applies first; pre-authorization required
	<u>Rehabilitation services</u>	\$30 / visit	20% coinsurance	Deductible applies first for out-of-network; limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy)
	<u>Habilitation services</u>	\$30 / visit	20% coinsurance	Deductible applies first for out-of-network; limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization may be required for certain services
	<u>Skilled nursing care</u>	10% coinsurance	30% coinsurance	Deductible applies first for out-of-network; limited to 100 days per calendar year; pre-authorization required
	<u>Durable medical equipment</u>	10% coinsurance	30% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network)
	<u>Hospice services</u>	10% coinsurance	30% coinsurance	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 dental check-up (covered for student only, under age 19)
- Children's eye exam (covered for student only, under age 19)
- Children's glasses (covered for student only, under age 19)
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam every 12 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: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 the state marketplace, please contact the Massachusetts Health Connector at www.mahealthconnector.org. 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).

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

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	\$150
■ Delivery fee coinsurance	10%
■ Facility fee copay/coinsurance	\$250/10%
■ Diagnostic tests coinsurance	10%

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
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$150
Copayments	\$268
Coinsurance	\$1,240

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$1,718
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$150
■ Specialist visit copay	\$30
■ Primary care visit copay	\$30
■ Diagnostic tests coinsurance	10%

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
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$134
Copayments	\$1,969
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$55
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The total Joe would pay is	\$2,158
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Jacquie's Simple Fracture

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

■ The plan's overall deductible	\$150
■ Specialist visit copay	\$30
■ Emergency room copay	\$150
■ Ambulance services coinsurance	10%

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
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In this example, Jacquie would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$300
Coinsurance	\$59

What isn't covered

Limits or exclusions	\$0
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The total Jacquie would pay is	\$359
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The plan would be responsible for the other costs of these EXAMPLE covered services.

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Summary of Benefits and Coverage: What This Plan Covers & What You Pay for Covered Services
Blue Care Elect Preferred 90 Copay Student Health Plan **Mount Ida College**

Coverage Period: on or after 08/10/2017
Coverage for: Individual only | **Plan Type:** PPO