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://semhg.org/**. 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.com/sbcglossary** or call **1-800-932-8323** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 member / $750 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, prenatal care, prescription drugs, most office visits, mental health visits, and therapy visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	$5,000 member / $10,000 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-billing 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 bluecrossma.com/findadoctor or call the Member Service number on your ID card 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.

HMO Option

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

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	None
	Specialist visit	$35 / visit; $20 / chiropractor visit; $35 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year
	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	Deductible applies first; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$100 for hospitals; no charge for other providers	Not covered	Deductible applies first; copayment applies per category of test / day; 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 **bluecrossma.com/medications**	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; 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 / 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	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	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 care	$100 / visit	$100 / visit	Deductible applies first; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$35 / visit	$35 / visit	Out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 / admission; $700 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	Pre-authorization 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	Not covered	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; 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	$300 / admission; $700 / admission for certain hospitals	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	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / 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	$20 / 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	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 services	No charge	Not covered	Deductible applies first; 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.)

- 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.)

- Acupuncture (12 visits per calendar year)
- 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 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)

■ **The plan's overall deductible**	**$250**
■ **Delivery fee copay**	**$0**
■ **Facility fee copay**	**$300**
■ **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$610**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist visit copay**	**$35**
■ **Primary care visit copay**	**$20**
■ **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist visit copay**	**$35**
■ **Emergency room copay**	**$100**
■ **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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

® Registered Marks of the Blue Cross and Blue Shield Association. © 2021 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

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://semhg.org**. 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:
What is the overall deductible?	$250 member / $750 family in-network; $400 member / $800 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, and prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	$5,000 member / $10,000 family in-network; $3,000 member out-of-network.	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-billing 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 bluecrossma.com/findadoctor or call the Member Service number on your ID card 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?	No.	You can see the specialist you choose without a referral.

PPO Option

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% coinsurance	Deductible applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care; a telehealth cost share may be applicable
	Specialist visit	$35 / visit; $20 / chiropractor visit; $35 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. 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	20% coinsurance	Deductible applies first; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	$100 for hospitals; No charge for other providers	20% coinsurance	Deductible applies first; copayment applies per category of test / day; pre-authorization may be required

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	$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; 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 / 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	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	20% coinsurance	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	In-network deductible applies first for in-network and out-of-network services; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	In-network deductible applies first for in-network and out-of-network services
	Urgent care	$35 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share 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)	$300 / admission; $700 / admission for certain hospitals	20% coinsurance	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization 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% coinsurance	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; 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); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$300 / admission; $700 / admission for certain hospitals	20% 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	Home health care	No charge	20% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first except for in-network outpatient services; limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network)
	Hospice services	No charge	20% coinsurance	Deductible applies first; 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 your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Deductible 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% coinsurance for members with a cleft palate / cleft lip condition	Deductible 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.)

- Children's glasses
- 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.)

- Acupuncture (12 visits per calendar year)
- 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 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 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)

■ **The plan's overall deductible**	**$250**
■ **Delivery fee copay**	**$0**
■ **Facility fee copay**	**$300**
■ **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$610**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist visit copay**	**$35**
■ **Primary care visit copay**	**$20**
■ **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist visit copay**	**$35**
■ **Emergency room copay**	**$100**
■ **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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.

MASSACHUSETTS

Mail Order Pharmacy

The Mail Order Pharmacy Saves You Time and Money

You can get 90-day prescriptions for certain maintenance medications delivered right to your door, and for a fraction of the cost, when you order them through the mail order pharmacy. Maintenance medications, also known as long-term medications, are prescribed to treat chronic or ongoing conditions, such as high blood pressure or diabetes.

Advantages of Using the Mail Order Pharmacy

- You'll pay less for a 90-day supply than you would for three 30-day supplies of your maintenance medications
- Medications are shipped to you at no additional cost for standard shipping
- With fewer refills and no trips to the pharmacy, you'll be less likely to miss a dose
- Get your prescriptions on time, every time with automatic refills

How to Order Prescriptions

Express Scripts®, an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts, will deliver your prescriptions straight to your door. To order prescriptions, choose one of the following options. In most cases, Express Scripts will contact your doctor directly to arrange 90-day prescriptions, plus refills.

- Visit Express Scripts at **express-scripts.com /starthd**, and select **Register**
- Download the Express Scripts mobile app and select **Register**
- Call Express Scripts at **1-800-892-5119** (TTY: **1-800-305-5376**)
- Ask your doctor to e-prescribe a new, 90-day prescription to Express Scripts, or fax it to **1-800-837-0959**
- Fill out the order form* and mail it to:

  Home Delivery Service
  PO Box 66566
  St Louis, MO 63166-9967

How to Order Refills

- Log in to Express Scripts at **express-scripts.com**, select the medications to be filled, then click **Add to Cart**
- Call Express Scripts at **1-800-892-5119** (TTY: **1-800-305-5376**), 24 hours a day

Have Your Prescriptions Refilled Automatically

Worry Free Fills® are available for qualifying maintenance medications. When enrolled, Express Scripts will calculate when you'll need your prescriptions and deliver them on time. They'll contact you before processing each fill to confirm delivery, and the delivery date. Enroll in Worry Free Fills by choosing one of the following methods:

- Visit Express Scripts at **express-scripts.com**, and select **Automatic Refills**
- When refilling a prescription, answer yes when asked to enroll in Worry Free Fills
- Call Express Scripts at **1-800-892-5119** (TTY: **1-800-305-5376**)

Save up to **33%** **When you use the mail order pharmacy.****

*You can download and print a copy of the mail order form at **express-scripts.com.**
**Compared to three 30-day prescriptions purchased at a retail pharmacy.

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

MASSACHUSETTS

Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

Before You Begin

Please carefully read the instructions below.

For members of HMO Blue,® Network Blue,® Blue Choice,® HMO Blue New England,℠ or Blue Choice New England℠: You're required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting **bluecrossma.com** and selecting **Find a Doctor**.

For Access Blue℠ Members: Although you're not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

Important: Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Please be sure to check either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Sections 2 and 3.

Please print two copies of your completed application. Keep one for your records and give the other to your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you're seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298
Fax: 1-617-246-7531

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association. ®, SM Registered Marks and Service Marks of the Blue Cross and Blue Shield Association. © 2017 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
163537 36-3630 (11/17)

Instructions

Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

Type of Transaction—Check the box(es) that apply.

Subscriber Cancellation Codes. If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling
041	• Changing to other health plan • Voluntary termination • COBRA cancellation (under 18 months or nonpayment)
042	• Over 65, changing to Group Medex® plan. (Requires Medicare A and B) • Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) • Over 65, changing to Medicare supplement other than Medex plans.
043	• Medicare (age =< 65)

Code #	Reason for Canceling
061	• Left employment • COBRA ending
063	• Transfer
064	• Cancellation as of original effective date
070	• Deceased
071	• Moved out of state (out of HMO service area)
076	• Military service

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions, contact your account service representative.
- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation. If you have questions, contact your account service representative.

Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID#—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (***not*** the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at **1-800-821-1388**. A representative will be happy to help you select a doctor. PCP ID number can be found at **bluecrossma.com**, select **Find a Doctor**.

Other Insurance—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*)) in the correct box. If you have other insurance, please write the name of the other insurance company and your member identification number.

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Member 2

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an **Individual** membership.)

Other Insurance—Does your spouse have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a **Family** membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: dependents cannot be covered under an **Individual** membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

For each option:

Start Date: Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated, and submitted the completed application for these accounts on or before that date.

End Date: Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions, please see your employer.

Note: If you are transferring from one medical/dental plan to another plan, please complete Section 5 of the Enrollment and Change Form to let us know that you will be continuing your personal savings account..

Section 6 Signatures (Employer & Employee)

Employee: Please sign and date the application and return it to your employer. Employer: Please sign and date the application and return to Blue Cross Blue Shieldof Massachusetts.

Please mail to:

P.O. Box 986001
Boston, MA 02298
or fax to 1-617-246-7531

* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

® Registered Marks of the Blue Cross and Blue Shield Association.
© 2017 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group # Transfering To:

Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group # Transferring To

Type of Transaction
❒ ADD ❒ CANCEL
❒ CHANGE Three digit termination code ☐☐☐
❒ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

❒ Open Enrollment ❒ New Hire ❒ COBRA

Change to Family ❒ Add Spouse ❒ Add Dependent

❒ Loss of Coverage (HIPAA Continuation of Coverage Letter required)

❒ Other: _____

2. Yourself (Member 1)

What products? ❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England ❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue ❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group) ❒ Network Blue ❒ PPO ❒ Saver Blue

Membership Type (Medical) ❒ Individual ❒ Family

Membership Type (Dental) ❒ Individual ❒ Family

First Name	M.I.	Last Name	Sex	Date of Birth

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Home Phone ( )	Cell Phone ( )	Email

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ❒ / N ❒	❒ 65+ ❒ Disabled ❒ ESRD / If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered)

Plan Type: ❒ Medical ❒ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ❒ / N ❒	❒ 65+ ❒ Disabled ❒ ESRD / If Retired, Date

4. Your Eligible Dependents (Member 3, 4 and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **HSA: Health Savings Account**			
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

Blue Cross Blue Shield of Massachusetts is an Independent Licence of the Blue Cross and Blue Shield Association.