



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://benefitsopenrollment.hologic.com>.

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](http://bluecrossma.org/sbcglossary) or call 1-800-358-2227 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$1,000 member / \$2,000 family in-network; \$2,000 member / \$4,000 family 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. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. In-network preventive and prenatal care.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$3,000 member / \$6,000 family in-network; \$5,000 member / \$10,000 family out-of-network.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> or call the Member Service number on your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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	\$25 / visit	40% <u>coinsurance</u>	<u>Deductible</u> applies first; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric <u>specialist</u> , nurse midwife, audiologist, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty <u>provider</u> group, or by a physician assistant or nurse practitioner designated as primary care; in-network <u>cost share</u> waived when visit is only for immunizations or injections
	<u>Specialist</u> visit	\$40 / visit; \$40 / chiropractor visit; \$40 / acupuncture visit	40% <u>coinsurance</u> ; 40% <u>coinsurance</u> / chiropractor visit; \$40 / acupuncture visit	<u>Deductible</u> applies first; includes physician assistant or nurse practitioner designated as specialty care; limited to 90 visits per calendar year for chiropractic services; in-network <u>deductible</u> applies first for in-network and out-of-network acupuncture services; limited to 20 visits per calendar year for acupuncture services; in-network <u>cost share</u> waived when visit is only for immunizations or injections
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; <u>cost share</u> waived for at least one mental health wellness exam per calendar year. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed

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)	
				are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.Caremark.com">www.Caremark.com</a>	Generic drugs	\$10 / \$20	Not Covered	Participating retail pharmacy/mail order program. All prescription drugs subject to a separate out-of-pocket maximum. (\$3,000 individual / \$6,000 family)
	Preferred brand drugs	\$40 / \$80	Not Covered	
	Non-preferred brand drugs	\$60 / \$120	Not Covered	
	<u>Specialty drugs</u>	\$150	Not Covered	\$0 cost share if eligible and enrolled in Prudent Rx program. 30% cost share if eligible but not enrolled in PrudentRx program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit	\$150 / visit	In-network <u>deductible</u> applies first for in-network and out-of-network services; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	In-network <u>deductible</u> applies first for in-network and out-of-network services
	<u>Urgent care</u>	\$40 / visit	40% <u>coinsurance</u>	<u>Deductible</u> 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 have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 / visit	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge for prenatal care; 10% <u>coinsurance</u> for postnatal care	40% <u>coinsurance</u>	<u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	\$40 / visit for outpatient services; 10% <u>coinsurance</u> for inpatient services	40% <u>coinsurance</u> for outpatient services; 40% <u>coinsurance</u> for inpatient services	<u>Deductible</u> applies first; limited to 100 outpatient visits per calendar year (other than for autism, Down syndrome, <u>home health care</u> , and speech therapy); limited to 180 days per calendar year combined with skilled nursing facilities; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$40 / visit	40% <u>coinsurance</u>	<u>Deductible</u> applies first; outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; limited to 180 days per calendar year combined with rehabilitation hospital inpatient care; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	40% <u>coinsurance</u> for members with a cleft palate / cleft lip condition	<u>Deductible</u> 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 eye exam | • Dental care (Adult)   | • Private-duty nursing     |
| • Children's glasses  | • Infertility treatment | • Routine eye care - adult |
| • Cosmetic surgery    | • Long-term care        |                            |

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

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|--|--|---|
| • Acupuncture (20 visits per calendar year)  | • Infertility treatment (3 Smart Cycles through Progyny) | • Routine foot care (only for patients with systemic circulatory disease) |
| • Bariatric surgery  | • Non-emergency care when traveling outside the U.S.     | • Weight loss & Fitness programs (\$150 per calendar year per policy)     |
| • Chiropractic care (90 visits per calendar year)  |  |   |
| • Hearing aids (\$2,500 for one hearing aid or one set of binaural hearing aids every 24 months for members 21 or younger; \$2,500 for one hearing aid or one set of binaural hearing aids, including covered services, every 24 months for members 22 or older) |  |   |

**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](http://www.dol.gov/ebsa/healthreform) and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.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](http://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](http://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](http://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 1-800-358-2227 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** \$1,000
- **Delivery fee coinsurance** 10%
- **Facility fee coinsurance** 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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900
<u>What isn't covered</u>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,970</b>

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

- **The plan's overall deductible** \$1,000
- **Specialist visit copay** \$40
- **Primary care visit copay** \$25
- **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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$5,340</b>

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

- **The plan's overall deductible** \$1,000
- **Specialist visit copay** \$40
- **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)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$1,410</b>

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