



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 <https://hughp.harvard.edu>. 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 1-617-495-2008 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u>? | \$250 member / \$750 family. | 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> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. <u>Preventive care</u> , prenatal care, emergency room, most office visits, mental health visits, therapy visits, <u>diagnostic tests</u> , and 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>? | \$1,500 member / \$4,500 family. | 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. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <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> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See hughp.harvard.edu 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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 | Not covered | A telehealth <u>cost share</u> may be applicable |
| | <u>Specialist</u> visit | \$30 / visit; \$30 / chiropractor visit; \$30 / acupuncture visit | Not covered | Limited to 18 chiropractor visits per calendar year; limited to 20 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed 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) | No charge | Not covered | <u>Pre-authorization</u> required for certain services |
| | Imaging (CT/PET scans, MRIs) | 10% <u>coinsurance</u> | Not covered | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com | Generic drugs | \$7/prescription retail \$14/prescription mail-order; \$0/prescription for specific preventive drugs | Not covered | Covers up to a 30-day supply purchased at retail. Covers up to 90-day supply purchased by mail order from Express Scripts. List of preventive drugs can be found at www.express-scripts.com |
| | Preferred brand drugs | \$20/prescription retail \$50/prescription mail-order; \$10/prescription retail \$25/prescription mail-order for specific preventive drugs | Not covered | Covers up to a 30-day supply purchased at retail. Covers up to 90-day supply purchased by mail order from Express Scripts. List of preventive drugs can be found at www.express-scripts.com |

| 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) | |
| | Non-preferred brand drugs | \$45/prescription retail; \$110/prescription mail-order | Not covered | Covers up to a 30-day supply purchased at retail. Covers up to 90-day supply purchased by mail order from Express Scripts. |
| | <u>Specialty drugs</u> | Copayments vary based on tier of prescription. Visit www.express-scripts.com for details. | Not covered | Covers up to a 30-day supply purchased at retail. Covers up to 90-day supply purchased by mail order from Express Scripts. |

| 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) | 10% <u>coinsurance</u> | Not covered | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | Not covered | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| If you need immediate medical attention | <u>Emergency room care</u> | \$100 / visit; <u>deductible</u> does not apply | \$100 / visit; <u>deductible</u> does not apply | <u>Copayment</u> waived if admitted or for observation stay |
| | <u>Emergency medical transportation</u> | No charge | No charge | None |
| | <u>Urgent care</u> | \$30 / visit | \$30 / visit | Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% <u>coinsurance</u> | Not covered | <u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | Not covered | <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 | \$30 / visit | Not covered | A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | Inpatient services | 10% <u>coinsurance</u> | Not covered | <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 | Not covered | <u>Deductible</u> applies first except for prenatal care; <u>cost sharing</u> does not apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable |
| | Childbirth/delivery professional services | 10% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 10% <u>coinsurance</u> | 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 | <u>Home health care</u> | 10% <u>coinsurance</u> | Not covered | <u>Deductible</u> applies first; <u>pre-authorization</u> required |
| | <u>Rehabilitation services</u> | \$30 / visit for outpatient services; 10% <u>coinsurance</u> for inpatient services | Not covered | <u>Deductible</u> applies first except for outpatient services; limited to 100 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | <u>Habilitation services</u> | \$30 / visit | Not covered | Outpatient rehabilitation therapy coverage limits apply; coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | <u>Skilled nursing care</u> | 10% <u>coinsurance</u> | Not covered | <u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required |
| | <u>Durable medical equipment</u> | 10% <u>coinsurance</u> | Not covered | <u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies |
| | <u>Hospice services</u> | 10% <u>coinsurance</u> | Not covered | <u>Deductible</u> applies first; <u>pre-authorization</u> 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 | Not covered | Limited to one exam per calendar year |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | No charge for members with a cleft palate / cleft lip condition | Not covered | 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
- 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 (20 visits per calendar year)
- Bariatric surgery
- Chiropractic care (18 visits per calendar year)
- Hearing aids
- Infertility treatment
- Routine eye care - adult (one exam per calendar year)
- 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 1-617-495-2008 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 <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Delivery fee coinsurance</u> | 10% |
| ■ <u>Facility fee coinsurance</u> | 10% |
| ■ <u>Diagnostic tests copay</u> | \$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:

| <u>Cost sharing</u> | |
|---------------------|---------|
| <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$1,100 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$1,420 |

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Specialist</u> visit <u>copay</u> | \$30 |
| ■ <u>Primary care</u> visit <u>copay</u> | \$30 |
| ■ <u>Diagnostic tests</u> <u>copay</u> | \$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:

| <u>Cost sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$4,300 |
| The total Joe would pay is | \$4,500 |

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Specialist</u> visit <u>copay</u> | \$30 |
| ■ <u>Emergency room</u> <u>copay</u> | \$100 |
| ■ <u>Ambulance services</u> <u>copay</u> | \$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:

| <u>Cost sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$300 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|-----------------------------------|--------------|
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$310 |

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