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 catholicbenefits.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 **1-800-832-3871** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** member / **$5,000** family in-network; **$5,000** member / **$10,000** 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, diagnostic tests, hospice services; emergency room, emergency transportation.	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?	**$3,000** member / **$6,000** family in-network; **$6,000** member / **$12,000** family 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.org/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.

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	40% coinsurance	Deductible applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietician nutritionist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care
	Specialist visit	$50 / visit; $30 / chiropractor visit; $30 / acupuncture visit	40% coinsurance; 40% coinsurance / chiropractor visit; 40% coinsurance / acupuncture visit	Deductible applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 18 chiropractor visits per plan year; limited to 12 acupuncture visits per plan year
	Preventive care/screening/immunization	No charge	40% coinsurance (routine adult exams not covered)	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency. 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)	$30	40% coinsurance	Deductible applies first for out-of-network; copayment applies per service date; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Deductible applies first; 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 www.catholicbenefits.org/health/rx.htm or **877-430-8633**	Generic drugs	Retail: $15 Mail: $30	Not covered	Deductible does not apply Pharmacy has a separate out of pocket maximum of $1,500 for individual coverage and $3,000 for family coverage Retail (up to 31-day supply)/Mail or Retail (32-90-day supply)
	Preferred brand drugs	Retail: $35 Mail: $70	Not covered	Deductible does not apply Pharmacy has a separate out of pocket maximum of $1,500 for individual coverage and $3,000 for family coverage Retail (up to 31-day supply)/Mail or Retail (32-90-day supply)
	Non-preferred brand drugs	Retail: $55 Mail: $110	Not covered	Deductible does not apply Pharmacy has a separate out of pocket maximum of $1,500 for individual coverage and $3,000 for family coverage Retail (up to 31-day supply)/Mail or Retail (32-90-day supply)
	Specialty drugs	Retail: $55 Mail: $110	Not covered	Deductible does not apply Pharmacy has a separate out of pocket maximum of $1,500 for individual coverage and $3,000 for family coverage Retail (up to 31-day supply)/Mail or Retail (32-90-day supply)

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)	20% coinsurance	40% coinsurance	Deductible applies first
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Deductible applies first
If you need immediate medical attention	Emergency room care	$250 / visit	$250 / visit	Copayment waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$50 / visit	40% coinsurance	Deductible applies first for out-of-network
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 / visit	40% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Inpatient services	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Office visits	No charge for prenatal care; 20% coinsurance for postnatal care	40% 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)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	$30 / visit	40% coinsurance	Deductible applies first for out-of-network; limited to 60 visits per plan year (other than for autism, home health care, and speech therapy)
	Habilitation services	$30 / visit	40% coinsurance	Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; in-network cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	20% coinsurance	40% coinsurance	Deductible applies first; limited to 100 days (combined with rehabilitation hospitals) per plan 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
	Hospice services	No charge	40% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	Deductible applies first for out-of-network; limited to one exam per plan year
	Children's glasses	No charge	No charge	Limited to $100 per plan year for one set of prescription lenses and / or frames or contact lenses
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	40% 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.)

- Abortion and other services that are not in keeping with teachings of the Catholic church
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Weight loss programs

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

- Acupuncture (12 visits per plan year)
- Bariatric surgery
- Chiropractic care (18 visits per plan year)
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment (coverage for diagnosis and some treatment per guidelines)
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam per plan year; $100 per plan year for one set of prescription lenses and / or frames or contact lenses)
- Routine foot care (only for patients with systemic circulatory disease)

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 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 1-800-832-3871 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

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

Does this plan meet the Minimum Value Standards? [Yes]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$2,500
■ Delivery fee coinsurance	20%
■ Facility fee coinsurance	20%
■ Diagnostic tests copay	$30

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$3,080**

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

■ The plan's overall deductible	$2,500
■ Specialist visit copay	$50
■ Primary care visit copay	$30
■ Diagnostic tests copay	$30

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,400**

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

■ The plan's overall deductible	$2,500
■ Specialist visit copay	$50
■ Emergency room copay	$250
■ Ambulance services copay	$0

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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