



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://www.smith.edu/about-smith/hr/benefits>. 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](http://bluecrossma.com/sbcglossary) or call 1-800-782-3675 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other <u>deductibles</u> for specific services?	Yes. \$100 member / \$200 family Rx <u>deductible</u> applies.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. 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> .
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,500 member / \$5,000 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 <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.
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> .

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 visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 / visit	Not covered	None
	<u>Specialist</u> visit	\$35 / visit; \$25 / chiropractor visit; \$35 / acupuncture visit	Not covered	Limited to 12 chiropractor visits per calendar year; limited to 20 acupuncture visits per calendar year
	<u>Preventive care/screening/immunization</u>	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<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)	No charge	Not covered	<u>Pre-authorization</u> required for certain services
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.optumrx.com">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> .	Generic drugs	30-Day Supply Retail Pharmacy Tier 1: \$10 Copayment 90-Day Supply Mail Order Pharmacy Tier 1: \$20 Copayment		None
	Preferred brand drugs	30-Day Supply Retail Pharmacy Tier 2: \$30 Copayment 90-Day Supply Mail Order Pharmacy Tier 2: \$60 Copayment		None
	Non-preferred brand drugs	30-Day Supply Retail Pharmacy Tier 3: \$50 Copayment 90-Day Supply Mail Order Pharmacy Tier 3: \$100 Copayment		None
	<u>Specialty drugs</u>	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 – 3		None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	Not covered	<u>Pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<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 you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit	\$150 / visit	<u>Copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$25 / visit	\$25 / visit	Out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 / admission	Not covered	<u>Copayments</u> not to exceed \$1,000 per calendar year for all inpatient admissions; <u>pre-authorization</u> required
	Physician/surgeon fees	No charge	Not covered	<u>Pre-authorization</u> required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 / visit	Not covered	<u>Pre-authorization</u> required for certain services
	Inpatient services	\$350 / admission	Not covered	<u>Copayments</u> not to exceed \$1,000 per calendar year for all inpatient admissions; <u>pre-authorization</u> required for certain services
If you are pregnant	Office visits	No charge	Not covered	<u>Copayments</u> not to exceed \$1,000 per calendar year for all inpatient admissions; <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)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$350 / admission	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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not covered	<u>Pre-authorization</u> required
	<u>Rehabilitation services</u>	\$25 / visit	Not covered	Limited to 60 visits per type of therapy per calendar year (other than for autism, <u>home health care</u> , and speech therapy); <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$25 / visit	Not covered	Rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	\$350 / admission	Not covered	<u>Copayments</u> not to exceed \$1,000 per calendar year for all inpatient admissions; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	No charge	Not covered	None
	<u>Hospice services</u>	No charge	Not covered	<u>Pre-authorization</u> required for certain services
<b>If your child needs dental or eye care</b>	Children's eye exam	\$25 / visit	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 (12 visits per calendar year)
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- 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](http://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](http://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](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 1-800-782-3675 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>	\$0
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$350
■ <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*)

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$460</b>

### 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>	\$0
■ <u>Specialist</u> visit <u>copay</u>	\$35
■ <u>Primary care</u> visit <u>copay</u>	\$25
■ <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*)

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> visit <u>copay</u>	\$35
■ <u>Emergency room</u> <u>copay</u>	\$150
■ <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*)

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

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