

# ShieldHOTELS

## Shield Hotels 2024-2025 Insurance Plan Premiums Westfield Barnes LLC Plan

Plan	Total Annual Cost	Total Monthly Cost	Employee Bi-Weekly Contribution	Employer Bi-Weekly Contribution	Total Bi-Weekly Cost
<b>HMO Blue New England Basic Saver</b>					
Individual	\$5,253.12	\$437.76	\$86.49	\$115.55	\$202.04
Employee + Spouse	\$10,506.12	\$875.51	\$288.53	\$115.55	\$404.08
Employee + Children	\$9,718.20	\$809.85	\$258.22	\$115.55	\$373.78
Family	\$14,971.20	\$1,247.60	\$460.26	\$115.55	\$575.82
<b>HMO Blue New England 1000 with Copay</b>					
Individual	\$ 8,124.60	\$ 677.05	\$ 156.24	\$ 156.24	\$ 312.48
Employee + Spouse	\$ 16,249.08	\$ 1,354.09	\$ 468.72	\$ 156.24	\$ 624.96
Employee + Children	\$ 15,030.48	\$ 1,252.54	\$ 421.85	\$ 156.24	\$ 578.10
Family	\$ 23,154.96	\$ 1,929.58	\$ 734.33	\$ 156.24	\$ 890.58
<b>Dental Blue 100-80-50</b>					
Individual	\$655.20	\$54.60	\$25.20	\$0.00	\$25.20
Family	\$1,605.36	\$133.78	\$61.74	\$0.00	\$61.74
<b>Blue 20/20 Insight Standard Vision</b>					
Individual	\$88.80	\$7.40	\$3.42	\$0.00	\$3.42
Employee + Spouse	\$150.96	\$12.58	\$5.81	\$0.00	\$5.81
Employee + Children	\$155.40	\$12.95	\$5.98	\$0.00	\$5.98
Family	\$244.32	\$20.36	\$9.40	\$0.00	\$9.40



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 [bluecrossma.org/coverage-info](https://bluecrossma.org/coverage-info). 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](https://bluecrossma.org/sbcglossary) or call 1-800-262-BLUE (2583) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$3,350 member / \$6,550 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> , prenatal care, and preventive drugs.	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>	Yes. For pediatric essential dental, \$50 member (no more than \$150 for three or more eligible members per family). There are no other specific <u>deductibles</u> .	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.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For medical and <u>prescription drug</u> benefits, \$7,100 member / \$14,200 family; and for pediatric essential dental, \$350 member (no more than \$700 for two or more eligible members per 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://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.

Important Questions	Answers	Why This Matters:
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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$45 / visit	Not covered	<u>Deductible</u> applies first; <u>copayment</u> waived for services at a limited services clinic; <u>cost share</u> waived for the first two diabetic PCP and / or <u>specialist</u> visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$75 / visit; \$75 / chiropractor visit; \$75 / acupuncture visit	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for the first two diabetic PCP and / or <u>specialist</u> visits per calendar year; limited to 12 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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$125 for x-rays and \$75 for lab tests for hospitals; \$25 for x-rays and \$15 for lab tests for other <u>providers</u>	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <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)	
	Imaging (CT/PET scans, MRIs)	\$1,000 for hospitals; \$750 for other providers	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> required for certain services
<p><b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a></p>	Generic drugs	\$10 / retail supply or \$20 / mail service supply for low-cost generic drugs; \$45 / retail supply or \$90 / mail service supply for other generic drugs	Not covered	<u>Deductible</u> applies first except for preventive drugs; up to 30-day retail (90-day mail service) supply; <u>cost share</u> may be waived or reduced for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$175 / retail supply or \$350 / mail service supply	Not covered	
	Non-preferred brand drugs	\$250 / retail supply or \$750 / mail service supply	Not covered	
	<u>Specialty drugs</u>	\$10 / retail supply for specialty preferred generic drugs; \$45 / retail supply for specialty non-preferred generic drugs; 50% <u>coinsurance</u> / retail supply for specialty preferred brand drugs; 50% <u>coinsurance</u> / retail supply for specialty non-preferred brand drugs; not covered / mail service supply	Not covered	<u>Deductible</u> applies first; up to 30-day retail supply; when obtained from a designated specialty pharmacy; <u>cost share</u> may be waived or reduced for certain covered drugs and supplies; specialty preferred brand drug <u>coinsurance</u> limited to \$350 per supply; specialty non-preferred brand drug <u>coinsurance</u> limited to \$500 per supply; <u>pre-authorization</u> 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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$1,000 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$1,500 / visit	\$1,500 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	<u>Deductible</u> applies first
	<u>Urgent care</u>	\$75 / visit	\$75 / visit	<u>Deductible</u> applies first; out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,500 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$45 / visit	Not covered	<u>Deductible</u> applies first; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$1,500 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
<b>If you are pregnant</b>	Office visits	No charge	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	No charge	Not covered	
	Childbirth/delivery facility services	\$1,500 / 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>Deductible</u> applies first; <u>pre-authorization</u> required
	<u>Rehabilitation services</u>	\$85 / visit for outpatient services; \$1,500 / admission for inpatient services	Not covered	<u>Deductible</u> applies first; limited to 60 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>	\$85 / visit	Not covered	<u>Deductible</u> applies first; limited to 60 visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); <u>copayment</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> may be required for certain services
	<u>Skilled nursing care</u>	\$1,500 / admission	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <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>	No charge	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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	Limited to one exam every 12 months until the end of the month a member turns age 19
	Children's glasses	35% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; limited to one set of prescription lenses and / or frames or contact lenses per calendar year until the end of the month a member turns age 19
	Children's dental check-up	No charge	Not covered	Limited to twice per calendar year until the end of the month a member turns age 19

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>		
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture (12 visits per calendar year)</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (\$2,000 per ear every 36 months)</li> <li>• Infertility treatment</li> <li>• Routine eye care - adult (one exam every 24 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care (only for patients with systemic circulatory disease)</li> <li>• Weight loss programs (\$150 per calendar year per policy)</li> </ul>

## Your Rights to Continue Coverage:

### If you have Individual health insurance:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 the state marketplace, please contact the Massachusetts Health Connector at [www.mahealthconnector.org](http://www.mahealthconnector.org). For more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583).

OR

### If you have Group health 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 1-800-472-2689 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.) You may also contact The Office of Patient Protection at 1-800-436-7757 or [www.mass.gov/hpc/opp](http://www.mass.gov/hpc/opp).

### 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)

■ <u>The plan's overall deductible</u>	\$3,350
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$1,500
■ <u>Diagnostic tests copay</u>	\$15

#### 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>	\$3,350
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,010</b>

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

■ <u>The plan's overall deductible</u>	\$3,350
■ <u>Specialist visit copay</u>	\$75
■ <u>Primary care visit copay</u>	\$45
■ <u>Diagnostic tests copay</u>	\$15

#### 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>	\$3,350
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,770</b>

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

■ <u>The plan's overall deductible</u>	\$3,350
■ <u>Specialist visit copay</u>	\$75
■ <u>Emergency room copay</u>	\$1,500
■ <u>Ambulance services 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:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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

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This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.



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Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$1,000 member / \$2,000 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> , prenatal care, <u>prescription drugs</u> , most office visits, and mental health visits.	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>	Yes. For pediatric essential dental, \$50 member (no more than \$150 for three or more eligible members per family). There are no other specific <u>deductibles</u> .	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.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For medical and <u>prescription drug</u> benefits, \$8,750 member / \$17,500 family; and for pediatric essential dental, \$350 member (no more than \$700 for two or more eligible members per 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://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.

Important Questions	Answers	Why This Matters:
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)	
<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	<u>Cost share</u> waived for services at a limited services clinic; <u>cost share</u> waived for the first two diabetic PCP and / or <u>specialist</u> visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$50 / visit; \$50 / chiropractor visit; \$50 / acupuncture visit	Not covered	<u>Cost share</u> waived for the first two diabetic PCP and / or <u>specialist</u> visits per calendar year; limited to 12 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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$80 for x-rays and \$40 for lab tests for hospitals; no charge for other <u>providers</u>	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$350 for hospitals; \$100 for other <u>providers</u>	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://bluecrossma.org/medication">bluecrossma.org/medication</a></p>	Generic drugs	\$10 / retail supply or \$20 / mail service supply for low-cost generic drugs; \$45 / retail supply or \$90 / mail service supply for other generic drugs	Not covered	Up to 30-day retail (90-day mail service) supply; <u>cost share</u> may be waived or reduced for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$100 / retail supply or \$200 / mail service supply	Not covered	
	Non-preferred brand drugs	\$225 / retail supply or \$675 / mail service supply	Not covered	
	<u>Specialty drugs</u>	\$10 / retail supply for specialty preferred generic drugs; \$45 / retail supply for specialty non-preferred generic drugs; 50% <u>coinsurance</u> / retail supply for specialty preferred brand drugs; 50% <u>coinsurance</u> / retail supply for specialty non-preferred brand drugs; not covered / mail service supply	Not covered	Up to 30-day retail supply; when obtained from a designated specialty pharmacy; <u>cost share</u> may be waived or reduced for certain covered drugs and supplies; specialty preferred brand drug <u>coinsurance</u> limited to \$350 per supply; specialty non-preferred brand drug <u>coinsurance</u> limited to \$500 per supply; <u>pre-authorization</u> 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)	\$250 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	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>	\$250 / visit	\$250 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	<u>Deductible</u> applies first
	<u>Urgent care</u>	\$50 / visit	\$50 / 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)	\$550 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	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	\$25 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$550 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge	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	No charge	Not covered	
	Childbirth/delivery facility services	\$550 / 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>Deductible</u> applies first; <u>pre-authorization</u> required
	<u>Rehabilitation services</u>	\$50 / visit for outpatient services; \$550 / admission for inpatient services	Not covered	<u>Deductible</u> applies first; limited to 60 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>	\$50 / visit	Not covered	<u>Deductible</u> applies first; limited to 60 visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> may be required for certain services
	<u>Skilled nursing care</u>	\$550 / admission	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	20% <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>	No charge	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 every 12 months until the end of the month a member turns age 19
	Children's glasses	35% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; limited to one set of prescription lenses and / or frames or contact lenses per calendar year until the end of the month a member turns age 19
	Children's dental check-up	No charge	Not covered	Limited to twice per calendar year until the end of the month a member turns age 19

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture (12 visits per calendar year)</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (\$2,000 per ear every 36 months)</li> <li>• Infertility treatment</li> <li>• Routine eye care - adult (one exam every 24 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care (only for patients with systemic circulatory disease)</li> <li>• Weight loss programs (\$150 per calendar year per policy)</li> </ul>

## Your Rights to Continue Coverage:

### If you have Individual health insurance:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 the state marketplace, please contact the Massachusetts Health Connector at [www.mahealthconnector.org](http://www.mahealthconnector.org). For more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583).

OR

### If you have Group health 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 1-800-472-2689 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.) You may also contact The Office of Patient Protection at 1-800-436-7757 or [www.mass.gov/hpc/opp](http://www.mass.gov/hpc/opp).

### 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>	\$1,000
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$550
■ <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:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,660</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>	\$1,000
■ <u>Specialist</u> visit <u>copay</u>	\$50
■ <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:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$2,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,520</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist</u> visit <u>copay</u>	\$50
■ <u>Emergency room</u> <u>copay</u>	\$250
■ <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:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

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

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This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

# DENTAL BLUE<sup>®</sup> PEDIATRIC + ADULT 2

## UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND  
BENEFITS



CLAIMS AND  
BALANCES



DIGITAL  
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Download the app, or create an account at [bluecrossma.org](https://bluecrossma.org).



This policy includes coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

# PEDIATRIC ESSENTIAL DENTAL BENEFITS

## Your Benefits

The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and out-of-pocket maximum amounts shown below. The calendar year begins on January 1 and ends on December 31 of each year. The chart below shows the percentage of costs your plan will pay for covered dental services. Many covered services have specific time limits.

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most you could pay during a calendar year for deductible and coinsurance for covered services in this portion of the plan. The out-of-pocket maximum is **\$350** per member (or **\$700** for two or more members). Costs that do not count towards your out-of-pocket maximum are premiums, any balance-billed charges, all dental services for members who are not eligible for pediatric essential dental benefits, and all services that this policy does not cover.

## When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan. Dental benefits in this portion of the plan are provided for members until the end of the calendar month in which they turn age 19.

## Orthodontic Benefits

Orthodontic benefits are available on or after your effective date. Coverage is only provided for medically necessary orthodontic care and requires prior authorization before services are provided. Orthodontic benefits are calculated using the allowed charge for the orthodontic procedure. You may be responsible for the coinsurance, and any difference between the Blue Cross Blue Shield payment and the dentist's actual charge. Please see your plan description (and riders, if any) for exact coverage details.

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	\$50 Per Member/\$150 Per Family Calendar-Year Deductible	
Full Coverage	80% Coverage	50% Coverage
<b>\$350 Per Member (\$700 for Two or More Members) Calendar-Year Out-of-Pocket Maximum</b>		
<p><b>Oral Exams</b></p> <ul style="list-style-type: none"> <li>One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures)</li> <li>Periodic or routine oral exams; twice in a calendar year</li> <li>Oral exams for a member under age three; twice in a calendar year</li> <li>Limited oral exams; twice in a calendar year</li> </ul> <p><b>X-rays</b></p> <ul style="list-style-type: none"> <li>Single tooth X-rays, as needed</li> <li>Bitewing X-rays; twice in a calendar year</li> <li>Full mouth X-rays; once in three calendar years per provider or location</li> <li>Panoramic X-rays; once in three calendar years per provider or location</li> </ul> <p><b>Routine Dental Care</b></p> <ul style="list-style-type: none"> <li>Routine cleaning, minor scaling, and polishing of the teeth; twice in a calendar year</li> <li>Fluoride treatments; once in 90 days</li> <li>Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered)</li> <li>Space maintainers</li> </ul>	<p><b>Fillings</b></p> <ul style="list-style-type: none"> <li>Amalgam (silver) fillings; one filling per tooth surface in 12 months</li> <li>Composite resin (white) fillings; one filling per tooth surface in 12 months</li> </ul> <p><b>Root Canal Treatment</b></p> <ul style="list-style-type: none"> <li>Root canals on permanent teeth; once per tooth</li> <li>Vital pulpotomy</li> <li>Retreatment of prior root canal on permanent teeth; once per tooth in 24 months</li> <li>Root end surgery on permanent teeth; once per tooth</li> </ul> <p><b>Crowns</b></p> <ul style="list-style-type: none"> <li>Prefabricated stainless steel crowns; once per tooth (primary and permanent)</li> </ul> <p><b>Gum Treatment</b></p> <ul style="list-style-type: none"> <li>Periodontal scaling and root planing; once per quadrant in 24 months</li> <li>Periodontal surgery; once per quadrant in 36 months</li> </ul> <p><b>Prosthetic Maintenance</b></p> <ul style="list-style-type: none"> <li>Repair of partial or complete dentures and bridges; once in 12 months</li> <li>Reline or rebase partial or complete dentures; once in 24 months</li> <li>Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth</li> </ul> <p><b>Oral Surgery</b></p> <ul style="list-style-type: none"> <li>Simple tooth extractions; once per tooth</li> <li>Erupted or exposed root removal; once per tooth</li> <li>Surgical extractions; once per tooth (approval required for complete, boney impactions)</li> <li>Other necessary oral surgery</li> </ul> <p><b>Other Necessary Services</b></p> <ul style="list-style-type: none"> <li>Dental care to relieve pain (palliative care)</li> <li>General anesthesia for covered oral surgery</li> </ul>	<p><b>Crowns</b></p> <ul style="list-style-type: none"> <li>Resin crowns; once per tooth in 60 months</li> <li>Porcelain/ceramic crowns; once per tooth in 60 months</li> <li>Porcelain fused to metal/high noble crowns; once per tooth in 60 months</li> </ul> <p><b>Tooth Replacement</b></p> <ul style="list-style-type: none"> <li>Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months</li> <li>Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months</li> </ul> <p><b>Implants</b></p> <ul style="list-style-type: none"> <li>Single tooth dental endosteal implants for members age 16 and older when the implant replaces permanent teeth through second molars; once per tooth in 60 months</li> </ul> <p><b>Other Necessary Services</b></p> <ul style="list-style-type: none"> <li>Occlusal guards when necessary; once in a calendar year</li> <li>Fabrication of an athletic mouth guard</li> </ul>
<p style="text-align: center;"><b>Orthodontic Benefit Group</b></p> <p><b>No deductible</b></p> <p><b>Coverage is only provided for medically necessary orthodontic care and requires prior authorization before services are provided.</b></p> <p><b>After prior authorization, you have:</b>  <b>50% coverage</b></p> <ul style="list-style-type: none"> <li>Braces for a member who has a severe and handicapping malocclusion</li> <li>Related orthodontic services for a member who qualifies</li> </ul>		

# DENTAL BENEFITS FOR MEMBERS AGE 19 AND OLDER

## Your Benefits

The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and benefit maximum amounts shown below. The calendar year begins on January 1 and ends on December 31 of each year. The chart below shows the percentage of costs your plan will pay for covered dental services. Many covered services have specific time limits.

## Your Benefit Maximum

Your benefit maximum is the most your plan will pay for covered services during a calendar year in this portion of the plan. Once your plan has paid the benefit maximum of \$1,000 per member, no additional dental benefits will be provided during that calendar year. When this happens, you must pay your the allowed charge for any services you receive for the rest of the calendar year.

## When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan. Dental benefits in this portion of the plan are provided for members who are age 19 and older and who are not eligible for pediatric essential dental benefits.

## Accumulated Maximum Rollover Benefits

This portion of the dental plan includes an Accumulated Maximum Rollover Benefit. This rollover benefit allows you to roll over a certain dollar amount of your unused annual dental benefits for use in the future. There are limits and restrictions on this benefit. Refer to the Accumulated Dental Maximum Rollover brochure for further information.

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	\$50 Per Member/\$150 Per Family Calendar-Year Deductible	
Full Coverage	80% Coverage	50% Coverage
<b>\$1,000 Per Member Calendar-Year Benefit Maximum</b>		
<p><b>Oral Exams</b></p> <ul style="list-style-type: none"> <li>Complete initial oral exam (includes initial history and charting of teeth and supporting structures); once in 60 months per provider or location</li> <li>Periodic or routine oral exams; twice in a calendar year</li> <li>Limited oral exams; twice in a calendar year</li> </ul> <p><b>X-rays</b></p> <ul style="list-style-type: none"> <li>Single tooth X-rays, as needed</li> <li>Bitewing X-rays; once in 6 months</li> <li>Full mouth X-rays; once in 60 months per provider or location</li> <li>Panoramic X-rays; once in 60 months per provider or location</li> </ul> <p><b>Routine Dental Care</b></p> <ul style="list-style-type: none"> <li>Routine cleaning, scaling, and polishing of the teeth; twice in a calendar year</li> <li>Periodontal cleanings; once every 3 months after active periodontal treatment, not to exceed twice in 12 months if combined with routine cleanings</li> </ul>	<p><b>Fillings</b></p> <ul style="list-style-type: none"> <li>Amalgam (silver) fillings; one filling per tooth surface in 12 months</li> <li>Composite resin (white) fillings; one filling per tooth surface in 12 months</li> <li>Temporary fillings; one filling per tooth</li> </ul> <p><b>Root Canal Treatment</b></p> <ul style="list-style-type: none"> <li>Root canals on permanent teeth; once per tooth</li> <li>Vital pulpotomy</li> <li>Retreatment of prior root canal on permanent teeth; once per tooth in 24 months</li> <li>Root end surgery on permanent teeth; once per tooth</li> </ul> <p><b>Gum Treatment</b></p> <ul style="list-style-type: none"> <li>Periodontal scaling and root planing; once per quadrant in 24 months</li> <li>Periodontal surgery; once per quadrant in 36 months</li> </ul> <p><b>Prosthetic Maintenance</b></p> <ul style="list-style-type: none"> <li>Repair of partial or complete dentures and bridges; once in 12 months</li> <li>Reline or rebase partial or complete dentures; once in 36 months</li> <li>Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth</li> </ul> <p><b>Oral Surgery</b></p> <ul style="list-style-type: none"> <li>Simple tooth extractions; once per tooth</li> <li>Erupted or exposed root removal; once per tooth</li> <li>Surgical extractions; once per tooth (approval required for complete, boney impactions)</li> <li>Other necessary oral surgery</li> </ul> <p><b>Other Necessary Services</b></p> <ul style="list-style-type: none"> <li>Dental care to relieve pain (palliative care)</li> <li>General anesthesia for covered oral surgery</li> </ul>	<p><b>Crowns</b></p> <ul style="list-style-type: none"> <li>Crowns; once per tooth in 60 months</li> <li>Replacement of crowns; once in 60 months</li> <li>Metallic, porcelain, and composite resin inlays or onlays; once per tooth in 60 months</li> <li>Replacement of metallic, porcelain, or composite resin inlays or onlays; once per tooth in 60 months</li> <li>Post and core buildup in addition to crown</li> </ul> <p><b>Tooth Replacement</b></p> <ul style="list-style-type: none"> <li>Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months</li> <li>Fixed bridges and crowns (when part of a bridge), including services to fabricate, measure, fit, and adjust them; once per tooth in 60 months</li> <li>Replacement of denture and bridges, but only when they are installed at least 60 months after the initial placement and only if the existing appliance cannot be made serviceable</li> <li>Temporary partial dentures to replace any of the six upper or lower front teeth, but only if they are installed immediately after the loss of teeth and during the period of healing</li> </ul> <p><b>Implants</b></p> <ul style="list-style-type: none"> <li>Single tooth dental endosteal implants when the implant replaces permanent teeth through second molars; once per tooth in 60 months</li> </ul>

# WELCOME TO DENTAL BLUE,

## A COMPREHENSIVE DENTAL PLAN PROVIDING BROAD NETWORK ACCESS TO MEET YOUR DENTAL CARE NEEDS.

### Your Dentist

Dental Blue offers an extensive network of dentists. Over 90 percent of dentists in Massachusetts and Rhode Island participate with Blue Cross Blue Shield of Massachusetts. Dental Blue members also have access to participating dentists nationwide.

If you would like help choosing a dentist, or already have a dentist and you want to know if they participate with your plan, you can call the dentist, look at the current dental provider directory, or call Member Service at the toll-free phone number shown on your Dental Blue ID card. You can also access the online dental provider directory at [bluecrossma.org](http://bluecrossma.org).

### Pre-Treatment Estimates and Prior Authorizations

If your dentist expects that your treatment will involve covered services that will cost more than \$250, Blue Cross Blue Shield recommends that your dentist send a copy of the "treatment plan" to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service.

Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

If your dentist has determined you will need a service that requires prior authorization, they must request approval for those services to be covered before services are provided. Prior authorization services that are done without obtaining approval may not be covered.

You will be responsible for all charges for services that are not approved or are done without prior authorization.

### Multi-Stage Procedures

Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures, and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure.

You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

### Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your plan description (and riders, if any) for exact coverage details.

### Enhanced Dental Benefits

Enhanced Dental Benefits for certain dental care services are available for members who have been diagnosed with qualifying conditions. To learn more about specific conditions included in this benefit, review your plan description (and riders, if any) on MyBlue at [bluecrossma.org](http://bluecrossma.org).

### How Dentists Are Paid – Participating Dentists

Dentists that participate with Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Rhode Island, or participating out-of-area dentists accept the lesser of either the dentist's actual charge or the allowed charge as payment in full for covered services. You pay only your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year benefit maximum.

In Massachusetts, benefits are usually only provided when covered services are received from a participating dentist. The exceptions are described in your plan description.

### How Dentists Are Paid – Non-participating Dentists Outside of Massachusetts

Benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on the dentist's actual charge or the allowed charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year benefit maximum.

### Supplemental Coverage – Non-participating Dentists Inside of Massachusetts

Your plan includes supplemental coverage to provide benefits for covered services received in Massachusetts from non-participating dentists. You may be responsible for the deductible and coinsurance (if applicable), any difference between the maximum allowance and the dentist's actual charge, and all charges beyond your calendar-year benefit maximum. See your plan sponsor for details and claim filing information.

### If You Have to File a Claim

Participating dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist when claims are received within one year of the completed service.

If you receive care from a non-participating dentist, you may have to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service. After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

If you have a grievance, see your plan description for instructions on how to file a grievance.

### Other Information

Coordination of benefits applies to plan members who are covered by another plan for health care expenses. Coordination of benefits ensures that payments from other insurance or health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause, which means that Blue Cross Blue Shield can recover payments if a member has already been paid for the same claim by a third party.

## QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-262-BLUE (2583), or visit us online at [bluecrossma.org](http://bluecrossma.org).

Limitations and Exclusions. These pages summarize the benefits of your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.



MASSACHUSETTS

# DENTAL BLUE<sup>®</sup> ACCUMULATED MAXIMUM ROLLOVER

At Blue Cross Blue Shield of Massachusetts, we know that oral health is a critical part of overall health. That's why we offer a dental benefit that will allow you to roll over a portion of your unused dental benefits from year to year.

## HOW MAXIMUM ROLLOVER WORKS

Beginning 60 days after the last day of your benefit period, your rollover amount will be added to your maximum benefit amount, increasing it for you to use that year and beyond (see below for amounts and maximums).

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross

doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

And, your rollover amount keeps growing and is available for you to use as long as your employer offers this rollover benefit.\* The last column will show you the total amount of additional benefit dollars you can earn. It's one more way we're working to improve health care for all our members.

You can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures.

This benefit applies to you automatically if:

- You receive at least one service during the benefit period
- You remain a member of the plan throughout the benefit period
- You don't exceed the claim payment threshold in the benefit period

If your dental plan's annual maximum benefit amount is:	And if your total claims don't exceed this amount for the benefit period:*	We'll roll over this amount for you to use next year and beyond:*	However, rollover totals will be capped at this amount:*
\$500–\$749	\$200	\$150	\$500
\$750–\$999	\$300	\$200	\$500
\$1,000–\$1,249	\$500	\$350	\$1,000
\$1,250–\$1,499	\$600	\$450	\$1,250
\$1,500–\$1,999	\$700	\$500	\$1,250
\$2,000–\$2,499	\$800	\$600	\$1,500
\$2,500–\$2,999	\$900	\$700	\$1,500
\$3,000 or more	\$1,000	\$750	\$1,500

\*This is not a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).  
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).  
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).



Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

## BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **[civilrightscoordinator@bcbsma.com](mailto:civilrightscoordinator@bcbsma.com)**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **[ocrportal.hhs.gov](https://ocrportal.hhs.gov)**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **[hhs.gov](https://hhs.gov)**.

# PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

**Spanish/Español:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

**Portuguese/Português:** ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

**Chinese/简体中文:** 注意: 如果您讲中文, 我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部 (TTY 号码: 711)。

**Haitian Creole/Kreyòl Ayisyen:** ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).

**Vietnamese/Tiếng Việt:** LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: 711).

**Russian/Русский:** ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: 711).

**Arabic/العربية:**

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النصي للصم والبكم "TTY": 711).

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជូនដំណឹង: ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: 711)។

**French/Français:** ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : 711).

**Italian/Italiano:** ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: 711).

**Korean/한국어:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: 711)를 사용하여 회원 서비스에 전화하십시오.

**Greek/Ελληνικά:** ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: 711).

**Polish/Polski:** UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

**Hindi/हिंदी:** ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निःशुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

**Gujarati/ગુજરાતી:** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કોલ કરો (TTY: 711).

**Tagalog/Tagalog:** PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: 711).

**Japanese/日本語:** お知らせ:日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください (TTY: 711)。

**German/Deutsch:** ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: 711).

**Persian/پارسیان:**

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شماره تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

**Lao/ພາສາລາວ:** ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

**Navajo/Diné Bizaad:** BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowólgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíjijí' béésh bee hodíílnih (TTY: 711).

Blue 20/20 is administered by EyeMed Vision Care®, an independent company.

Vision care service	In-network member cost	Out-of-network reimbursement <sup>1</sup>
<b>Comprehensive eye exam</b>	\$10 copay	up to \$50
<b>Contact lens fit and follow-up<sup>2</sup></b>		
• Standard	up to \$40	n/a
• Premium	10% off retail price	n/a
<b>Retinal imaging</b>	up to \$39	n/a
<b>Enhanced Diabetes Eye Care Benefit<sup>3</sup></b> For members diagnosed with type 1 or type 2 diabetes	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	n/a
<b>Frames</b>	\$130 allowance, then additional 20% off balance	up to \$74
<b>Standard plastic lenses</b>		
• Single vision	\$25 copay	up to \$42
• Bifocal	\$25 copay	up to \$78
• Trifocal	\$25 copay	up to \$130
• Lenticular	\$25 copay	up to \$130
• Standard progressive lens	\$90 copay	up to \$140
• Premium progressive lens tier 1–tier 3	\$110–\$135 copay	up to \$196
• Premium progressive lens tier 4	\$90 copay, then 80% of charge less \$120 allowance	up to \$196
<b>Lens options<sup>2</sup></b>		
• UV treatment	\$15	n/a
• Tint (solid and gradient)	\$15	n/a
• Standard plastic scratch coating	\$15	n/a
• Standard polycarbonate	\$40	n/a
• Standard polycarbonate for covered dependents under age 19	Paid in full	up to \$26
• Standard anti-reflective coating	\$45	n/a
• Premium anti-reflective coating	\$57–\$68	n/a
• Photochromic/Transitions® plastic	\$75	n/a
• Polarized	20% off retail price	n/a
• Other add-ons	20% off retail price	n/a
<b>Contact lenses<sup>4</sup></b>		
• Conventional	\$130 allowance, then additional 15% off balance	up to \$104
• Disposable	\$130 allowance	up to \$104
• Medically necessary	Paid in full	up to \$210
<b>Frequency</b>		
• Exam	once every 12 months	
• Lenses for frames or one order of contact lenses	once every 12 months	
• Frames	once every 24 months	

### Additional in-network savings and discounts

<b>40% OFF</b>	a complete second pair of glasses
<b>20% OFF</b>	non-prescription sunglasses
<b>15% OFF</b>	retail price or 5% off promotional price for laser vision correction through U.S. Laser Network

**Customer service:**  
**1-855-875-6948**  
To locate an in-network provider, visit [blue2020ma.com](http://blue2020ma.com).  
\*Registration not required to search for providers.

### Save on hearing exams and hearing aids

Offered by Amplifon Hearing, an independent company.

To learn more about the savings available, visit [amplifonusa.com/blue2020](http://amplifonusa.com/blue2020).

Call **1-866-921-5367** to get started.

**Choose from thousands of independent and retail providers including:**



For costs and further details of the coverage, including exclusions, please refer to your member booklet.

1. Your actual expenses for covered services may exceed the stated out-of-network amount.
2. Indicates a service that is a discounted arrangement as part of your vision plan.
3. Consult with your eye care provider.
4. Discount applies to materials only and not fittings for contact lenses.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call the EyeMed Network/Patient Services number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de EyeMed Network/Servicio al Paciente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se você não fala inglês, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para a EyeMed Network/Serviços ao Paciente usando o número no seu cartão de ID (TTY: 711).



# Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(expires 12-31-2026)

## PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

### Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%<sup>1</sup> of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.<sup>12</sup>

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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<sup>1</sup> Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

## When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

## What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

## How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Danielle Michael**

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name 66 Greenfield LLC & Westfield Barnes LLC		4. Employer Identification Number (EIN)	
5. Employer address 63 Myron Street		6. Employer phone number	
7. City West Springfield	8. State MA	9. ZIP code 01089	
10. Who can we contact about employee health coverage at this job? Danielle Michael			
11. Phone number (if different from above)		12. Email address shield@shieldhotels.com	

Here is some basic information about health coverage offered by this employer:

• As your employer, we offer a health plan to:

All employees. Eligible employees are:

All employees who work an average of 30 or more hours per week.

Some employees. Eligible employees

• With respect to dependents:

We do offer coverage. Eligible dependents

Spouse and Dependent Children of an employee who works an average of 30 or more hours per week.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

\*\* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

**Yes** (Continue)  
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? \_\_\_\_\_ (mm/dd/yyyy) (Continue)

**No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard\*?  
 Yes (Go to question 15)  No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard\* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.  
a. How much would the employee have to pay in premiums for this plan? \$ N/A ER is not an applicable large Employer.  
b. How often?  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? \_\_\_\_\_

Employer won't offer health coverage  
 Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ \_\_\_\_\_  
b. How often?  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  Yearly

X

\* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)