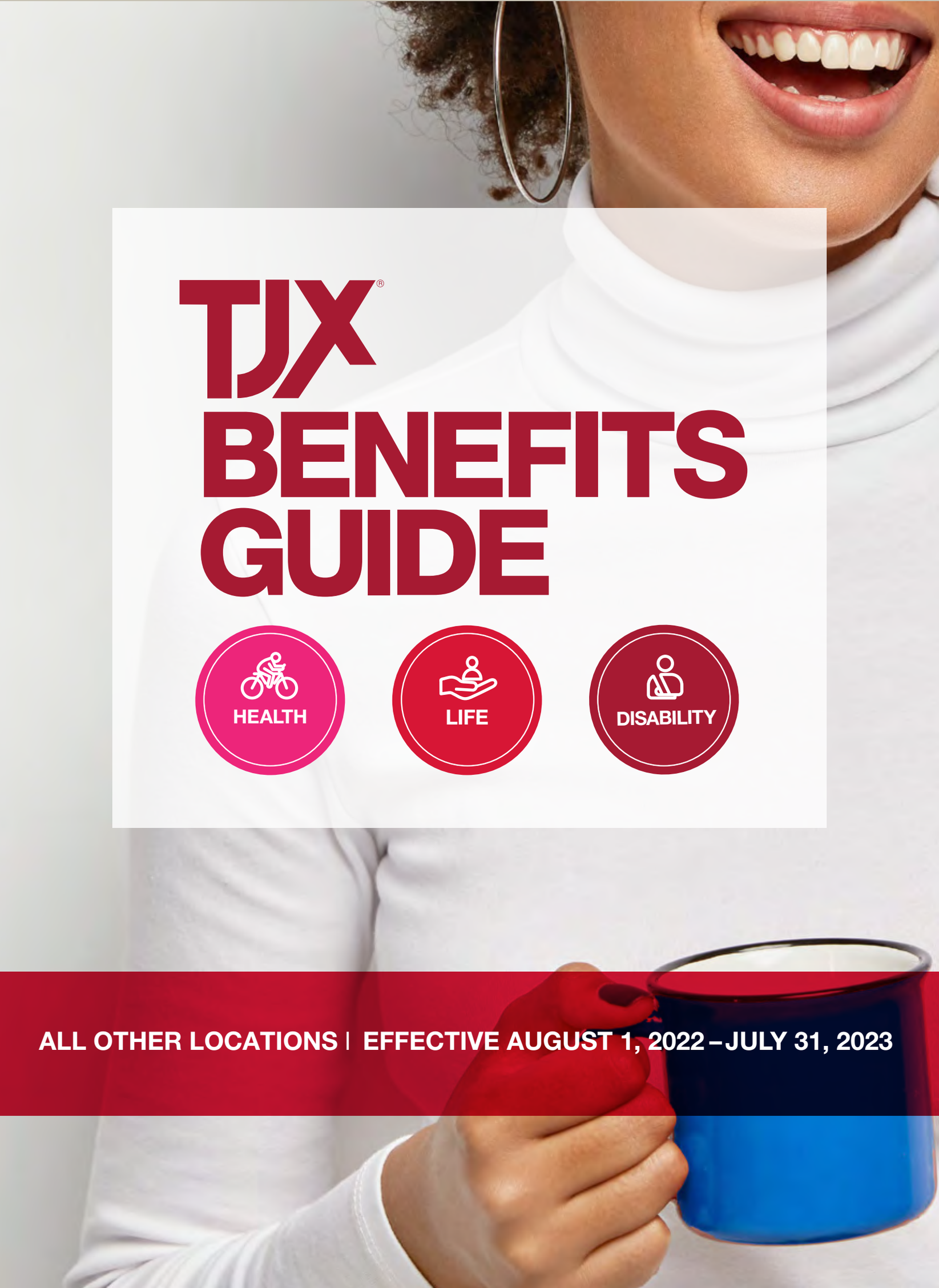

# TJX®

# BENEFITS GUIDE

HEALTH

LIFE

DISABILITY

**ALL OTHER LOCATIONS | EFFECTIVE AUGUST 1, 2022 – JULY 31, 2023**

# WELCOME TO YOUR TJX BENEFITS GUIDE

**This brochure explains the TJX health, life and disability benefits that are available to you for the August 1, 2022 through July 31, 2023 coverage period. It's important to review this guide to help you decide which benefits best satisfy your personal situation. In addition, please look at the accompanying materials for instructions on how to enroll or make changes.**

## DO I NEED TO RE-ENROLL EVERY YEAR?

If you're already enrolled in **medical, the Health Savings Account (HSA), dental, vision, life insurance and/or disability benefits** and don't want to make any changes, you don't need to do anything.

However, participation in the **Health Care Flexible Spending Account (FSA)** requires that you re-enroll during each Open Enrollment period.

*Please refer to your Summary Plan Description (SPD) for more detailed information on each benefit, including eligibility, coverage, maximums, limitations and exclusions.*

## WHO CAN I COVER?

**SINGLE**

YOURSELF

**FAMILY**

YOURSELF & ELIGIBLE FAMILY MEMBERS

Eligible family members include:

- Your legal spouse
- Your children through age 25

*Note that the following dependents are NOT eligible for coverage, even if they are living with you: former spouse (except under the dental plan in some cases; refer to your SPD), common law spouse, domestic partner (e.g., girlfriend or boyfriend), parent, grandparent, in-law; or cousin, niece, nephew or grandchild, unless you have legal custody/guardianship.*

## HOW MUCH WILL MY BENEFITS COST ME?

Your weekly cost for each benefit can be found in Employee Self Service (ESS), with the exception of the HSA and FSA (if elected). Weekly deductions for the HSA and FSA will depend upon the contribution you elect.

Keep in mind that you pay for your benefits with pre-tax dollars, with the exception of Dependent Life Insurance and Long Term Disability, which you pay for with after-tax dollars.

*Social Security benefits are based on your salary history. Benefits that are provided on a pre-tax basis (medical, HSA, FSA, dental, vision care, Optional Life Insurance and Accidental Death & Dismemberment) may reduce your amount of taxable salary. This may ultimately reduce the amount of your Social Security benefits. However, the reduction may be offset by the lower taxes that you pay now. Benefits that you elect and pay for with pre-tax dollars are only offered on a pre-tax basis.*

# MEDICAL PLANS

ADMINISTERED BY BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC.

## CONSUMER'S CHOICE (PPO) WITH HSA

| MEDICAL PLAN FEATURES | YOUR COST | |
|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK |
| **Choice of Provider** | Members use participating providers | Members use non-participating providers |
| **Coverage-Period Deductible** *(August 1 through July 31)* | $1,400 per member per coverage period<br>$2,800 per family per coverage period<br>Note: The entire family deductible must be met before benefits will be provided for any one member. | |
| **Annual Out-of-Pocket Maximum** | $4,000 per member per coverage period<br>$6,000 per family per coverage period | |
| **Lifetime Maximum Benefit** | None | |
| **SERVICES** | | |
| **Physician's Office Visits** | $25 copayment per visit after deductible | 40% coinsurance after deductible |
| **Preventive Care**[1] | | |
| **Routine pediatric and adult physical exams** | No cost to you | 40% coinsurance after deductible |
| **Routine lab tests, X-rays and immunizations** | No cost to you | 40% coinsurance after deductible |
| **Routine mammograms, Pap smear tests and colonoscopies** | No cost to you | 40% coinsurance after deductible |
| **Hospital Services** | | |
| **Outpatient surgery** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Inpatient facility & physician services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Emergency Room** | $150 copayment per visit after deductible; copayment waived if admitted | |
| **Urgent Care Center** | $25 copayment per visit after deductible | 40% coinsurance after deductible |
| **Diagnostic Lab & X-rays** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Mental Health & Substance Abuse Treatment** | | |
| **Outpatient services** | $25 copayment per visit after deductible | 40% coinsurance after deductible |
| **Inpatient services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **PRESCRIPTION MEDICATION**[2] | | |
| **Retail Pharmacy** *(up to a 30-day supply)* | | |
| **Tier 1:** Generic | $10 copayment after deductible | Not covered |
| **Tier 2:** Preferred brand name | $35 copayment after deductible | Not covered |
| **Tier 3:** Non-preferred brand name | $50 copayment after deductible | Not covered |
| **Mail-Service Pharmacy** *(up to a 90-day supply)* | | |
| **Tier 1:** Generic | $20 copayment after deductible | Not covered |
| **Tier 2:** Preferred brand name | $85 copayment after deductible | Not covered |
| **Tier 3:** Non-preferred brand name | $120 copayment after deductible | Not covered |

[1] *Some preventive care services may be subject to age-based schedules and/or frequency limitations.*

[2] *Important notes about prescription medication:*

- */ Coverage is based on the Blue Cross Blue Shield drug formulary. Not all drugs are covered by the plan.*
- */ Maintenance medications must be filled as a 90-day supply either through the mail-service pharmacy or at a CVS retail pharmacy. Otherwise, you will pay the full cost of the medication.*
- */ Preventive medications are not subject to the deductible.*
- */ If you choose to fill a brand name drug when there is a generic equivalent available, you will pay the generic copayment, plus the difference in cost between the brand name and the generic drug.*
- */ Your out-of-pocket costs for specialty drugs covered under the PillarRx Cost Share Assistance Program will range from $0 to $35 once enrolled in the program. You will be subject to 30% coinsurance if you do not enroll.*

# MEDICAL PLANS

ADMINISTERED BY BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC.

## OPTION-A-PLUS (PPO)

| MEDICAL PLAN FEATURES | YOUR COST | |
|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK |
| **Choice of Provider** | Members use participating providers | Members use non-participating providers |
| **Calendar-Year Deductible** *(January 1 through December 31)* | $325 per member per calendar year<br>$650 per family per calendar year | $650 per member per calendar year<br>$1,300 per family per calendar year |
| **Annual Out-of-Pocket Maximum** | $2,500 per member per calendar year<br>$5,000 per family per calendar year | $3,750 per member per calendar year<br>$7,500 per family per calendar year |
| **Lifetime Maximum Benefit** | None | |
| **SERVICES** | | |
| **Physician's Office Visits** | $25 copayment per visit | 40% coinsurance after deductible |
| **Preventive Care**[3] | | |
| **Routine pediatric and adult physical exams** | No cost to you | 40% coinsurance after deductible |
| **Routine lab tests, X-rays and immunizations** | No cost to you | 40% coinsurance after deductible |
| **Routine mammograms, Pap smear tests and colonoscopies** | No cost to you | 40% coinsurance after deductible |
| **Hospital Services** | | |
| **Outpatient surgery** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Inpatient facility & physician services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Emergency Room** | $150 copayment per visit; copayment waived if admitted | |
| **Urgent Care Center** | $25 copayment per visit | 40% coinsurance after deductible |
| **Diagnostic Lab & X-rays** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Mental Health & Substance Abuse Treatment** | | |
| **Outpatient services** | $25 copayment per visit | 40% coinsurance after deductible |
| **Inpatient services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **PRESCRIPTION MEDICATION**[4] | | |
| **Retail Pharmacy** *(up to a 30-day supply)* | | |
| **Tier 1:** Generic | $10 copayment | Not covered |
| **Tier 2:** Preferred brand name | $35 copayment | Not covered |
| **Tier 3:** Non-preferred brand name | $50 copayment | Not covered |
| **Mail-Service Pharmacy** *(up to a 90-day supply)* | | |
| **Tier 1:** Generic | $20 copayment | Not covered |
| **Tier 2:** Preferred brand name | $85 copayment | Not covered |
| **Tier 3:** Non-preferred brand name | $120 copayment | Not covered |

[3] *Some preventive care services may be subject to age-based schedules and/or frequency limitations.*

[4] *Important notes about prescription medication:*

- */ Coverage is based on the Blue Cross Blue Shield drug formulary. Not all drugs are covered by the plan.*
- */ Maintenance medications must be filled as a 90-day supply either through the mail-service pharmacy or at a CVS retail pharmacy. Otherwise, you will pay the full cost of the medication.*
- */ If you choose to fill a brand name drug when there is a generic equivalent available, you will pay the generic copayment, plus the difference in cost between the brand name and the generic drug.*
- */ Your out-of-pocket costs for specialty drugs covered under the PillarRx Cost Share Assistance Program will range from $0 to $35 once enrolled in the program. You will be subject to 30% coinsurance if you do not enroll.*

# HEALTH SAVINGS ACOUNT (HSA)

ADMINISTERED BY HEALTHEQUITY, INC.

**Available to Associates enrolled in the CONSUMER'S CHOICE medical plan.**

An HSA is a tax-advantaged account that allows you to set aside money to pay for qualified medical, dental and vision care expenses for you, your spouse and qualified dependents.[5]

## HOW IT WORKS

By enrolling in the Consumer's Choice medical plan, you authorize TJX to automatically establish an HSA with HealthEquity and TJX will make a lump-sum contribution to your account as shown below. You will receive this employer contribution once each calendar year, as long as you are enrolled in the Consumer's Choice medical plan at the time the contribution is made.

- Exempt Associates, Store Management, Loss Prevention Investigators/Associate Investigators, and hourly Associates working in the Home Office, Regional/Zone Office, Buying Office and Distribution/Fulfillment Center Office who earn $26.80 or more per hour will receive $200 if enrolled in single coverage and $400 if enrolled in family coverage.
- All other Associates will receive $300 if enrolled in single coverage and $600 if enrolled in family coverage.

In addition to the employer contribution, you may elect to contribute your own money to your account via weekly pre-tax payroll deductions. You must be enrolled in the Consumer's Choice medical plan on the first day of the month in order to make contributions during that month. The maximum amount you may contribute during the 2022 calendar year—inclusive of your contribution and TJX's contribution—is **$3,650** if enrolled in single medical coverage and **$7,300** if enrolled in family medical coverage. Please note that these dollar limits are subject to change each January 1. If you are age 55 or older by the end of the calendar year, you may contribute an additional $1,000.

HSA contribution limits are determined on a calendar-year basis and must generally be prorated by the number of months you are eligible to contribute to an HSA. However, the Last Month Rule states that if you are covered by an HSA-eligible health plan on the first day of the last month of a given year, you are considered an eligible individual for that entire year, provided you remain eligible for the next 12 months following the last month of that tax year. Excess contributions are considered taxable and may be subject to a penalty. Consult a tax advisor for additional information. You may change or stop your HSA deduction at any time.

HealthEquity will mail you a debit card that may be used to pay for expenses. It is important to note that you may only spend up to the available balance in your HSA at any point in time. Also, any unused funds in your HSA at the end of a year will automatically be rolled over for future use. Your account balance grows tax-free and disbursements made for qualified health care expenses are also tax-free. Once your account reaches $1,000, you can invest your money in the plan's line of mutual funds to maximize your account's tax-free earning potential. Once enrolled, you should designate a beneficiary for the funds in your account.

**If you leave the Company or retire, you take your HSA with you and you can continue to use it to pay for qualified health care expenses.** However, unless you enroll in another qualified high-deductible health plan, you will no longer be able to make contributions to an HSA.

## QUALIFIED AND NON-QUALIFIED EXPENSES

Qualified expenses include some of the common health care expenses that have not been (and cannot be) reimbursed through any other health plan. This means that your HSA can be used to cover expenses subject to the deductible of the Consumer's Choice plan, as well as coinsurance, copayments, prescription drugs, dental and vision expenses. In addition, diabetic supplies, bandages, crutches, first-aid kits, menstrual care products, contact lens solution and over-the-counter (OTC) medications used for the treatment of an illness or injury (e.g., cold and cough medicine, pain relievers, allergy medications and antacids) are included as qualified expenses. A complete list of qualified expenses may be obtained online at the Internal Revenue Service website (irs.gov).

## IMPORTANT NOTES

**The HSA is only available to Associates who are enrolled in the high-deductible health plan (Consumer's Choice), and who are not enrolled in or eligible to receive benefits from any other health plan, including Medicare and a Health Care FSA (including a spouse's Health Care FSA).[6] If you are enrolling in Consumer's Choice and are also enrolled in another health plan, you must contact HR XPRESS so that TJX does not establish an HSA in your name.**

**While actively employed and enrolled in a high-deductible health plan, you can contribute to your HSA via weekly pre-tax deductions. If you are enrolled in a high-deductible health plan upon or during retirement, any contributions you make to an HSA are tax-deductible.**

*[5] According to federal regulations and guidance, qualified dependents under the HSA include your legally married spouse and any individual who qualifies as your dependent for income tax purposes.*

*[6] Because you cannot contribute to the HSA while you are also eligible to receive reimbursement from an FSA, when you enroll in the HSA, all funds remaining in your FSA at the end of the coverage period, including any funds eligible for carryover to the next coverage period, will be automatically forfeited.*

# HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

ADMINISTERED BY HEALTHEQUITY, INC.

This benefit allows you to set aside pre-tax money from your paycheck to pay for certain medical, dental and vision care expenses that are not covered by your insurance. Money that you contribute to the FSA is best used for predictable health care expenses that will be incurred by you, your spouse and qualified dependents.[7]

## HOW IT WORKS

The maximum amount you may set aside is **$2,850** for the coverage period (August 1–July 31). The annual amount you elect will be divided equally by the number of pay periods remaining in the coverage period and will be deducted weekly from your paycheck on a pre-tax basis. HealthEquity will deposit your total annual election into an account for you. You may then use the funds in the account to pay for qualified FSA expenses that are incurred during the coverage period. **(See the "$570 carryover" note below for more information.)**

**You will receive a personalized HealthEquity Healthcare Card (fully loaded with your annual election) which will be mailed to your home.**

The Healthcare Card is similar to a debit card and may be used at most health care provider offices and at pharmacies to pay for qualified expenses. If you don't use the Healthcare Card, you may submit a reimbursement claim at wageworks.com or through the EZ Receipts® mobile app.

## QUALIFIED AND NON-QUALIFIED EXPENSES

Qualified expenses include some of the common medical, prescription drug, dental, vision and health-related expenses, including coinsurance, copayments and deductibles, that have not been (and cannot be) reimbursed through any other health plan. In addition, diabetic supplies, bandages, crutches, first-aid kits, menstrual care products, contact lens solution and over-the-counter (OTC) medications used for the treatment of an illness or injury (e.g., cold and cough medicine, pain relievers, allergy medications and antacids) are included as qualified expenses.

A complete list of qualified expenses may be obtained online at the IRS website (irs.gov).

**Keep track of your account and expenses.** Please retain all receipts in the event that HealthEquity requests additional substantiation for an eligible expense. To help you keep track of your balance and claims, you may visit the HealthEquity website to review your account online.

## IMPORTANT NOTES

**Unlike other benefits, FSA elections cannot automatically roll over into the next coverage period. You must re-enroll each year during the annual Open Enrollment period.**

**Call HR XPRESS if you are enrolled in Consumer's Choice but are not eligible for the HSA and wish to enroll in the FSA.**

**Coverage period.** The FSA coverage period runs from August 1 through July 31.

**Changing your contributions.** You may not change or stop your contributions during the coverage period, unless you have a qualifying life event (e.g., marriage, divorce, birth or adoption of a child or death of a dependent).

**Select "credit" at the register.** When you use your HealthEquity Healthcare Card select "credit," even though it indicates "debit" on the card.

**If you leave the Company.** Claims must be filed within 90 days of your termination date for expenses incurred prior to termination. Any claims filed after the deadline will be denied, and you will forfeit any balance remaining in your FSA.

**Run-out period.** Qualified expenses incurred during the coverage period must be submitted for reimbursement by November 28, 2023.

**$570 carryover.**[8] IRS regulations permit you to carry over up to $570 of unused funds remaining in your FSA at the end of the coverage period to pay for qualified expenses that you incur during the next coverage period. This carryover does not impact your contribution for the next coverage period—you may still set aside up to the maximum of $2,850. Any funds in excess of $570 remaining in your FSA at the end of the coverage period's run-out period will be forfeited. If you do not re-enroll in the FSA for the next coverage period and you have a balance of less than $5, you will not be eligible for the carryover and the remaining amount will be forfeited.

*[7] According to federal regulations and guidance, qualified dependents under the FSA include your legally married spouse, any individual who qualifies as your dependent for income tax purposes, and any dependent child until the end of the calendar year in which he/she reaches age 26.*

*[8] You will not be able to take advantage of this $570 carryover if you enroll in the Consumer's Choice plan for the following coverage period and contribute to the HSA. Because you cannot contribute to the HSA while you are also eligible to receive reimbursement from an FSA, when you enroll in the HSA, all funds remaining in your FSA at the end of the coverage period, including any funds eligible for carryover to the next coverage period, will be automatically forfeited. You will still be able to submit claims incurred during the coverage period for reimbursement during the run-out period.*

# RESOURCES TO HELP MANAGE YOUR HEALTH CARE

## ALEX
(DECISION SUPPORT TOOL)

Deductibles, out-of-pocket maximums, HSAs and FSAs can be confusing. How do you know which medical plan is the right fit for you? ALEX can help!

ALEX is an interactive tool that can help you consider which medical plan might be right for you—in everyday language and without all the benefits jargon.*

**To access ALEX, visit myalex.com/tjx/2022 before you make your benefits elections.**

## FOR BLUE CROSS BLUE SHIELD MEMBERS:

### WELL CONNECTION
(TELEHEALTH)

Your telehealth benefit offers a low-cost, convenient alternative to emergency room visits.

Using Well Connection, licensed doctors can diagnose and treat medical and behavioral health conditions, such as cold and flu, sinus infections, skin rashes, eye irritation, depression, anxiety, and more. They can even write prescriptions when necessary.**

In most cases, there is no cost to you when using Well Connection. The only exception is that Associates enrolled in Consumer's Choice must first meet their deductible before full coverage applies.

**Download and register for the Blue Cross of MA MyBlue app. From the Home menu, select My Care and click on Well Connection Video Visits under Remote Care.**

### FITNESS REIMBURSEMENT

Members may receive a reimbursement of up to $150 per family per calendar year for eligible fitness-related expenses such as:

- Membership fees at a full-service health club with cardiovascular and strength-training equipment or for online subscriptions, programs or classes that provide cardiovascular and strength training using a digital platform (e.g. Aaptiv, ClassPass, CorePower Yoga, Grokker, Peloton)
- Fitness class fees at a fitness studio with instructor-led group classes (e.g. yoga, kickboxing, indoor cycling)
- Large fitness equipment for home use (e.g. stationary bike, elliptical, rowing machine, treadmill)

*Note: These reimbursements are considered taxable income. The amount of your reimbursement will be added to your earnings, and will be subject to tax withholding, after your reimbursement is made.*

**To learn more or submit a claim for reimbursement, log in to bluecrossma.org/myblue or download the Blue Cross of MA MyBlue app.**

### SMARTSHOPPER

SmartShopper allows you to compare costs for certain medical services (such as MRIs, colonoscopies and mammograms) and to earn cash by using reward-eligible providers.*** Cash rewards range from $25 to $250, depending on the type of service.

**To get started, log in to bluecrossma.org/myblue. From the My Care tab, click on the SmartShopper link, or call a Personal Assistant at 877-281-3722.**

### LIVONGO
(DIABETES SUPPORT)

Livongo combines the latest technology with coaching to support members in managing their diabetes. Join Livongo and get a connected meter, unlimited test strips, personalized insights and coaching at no cost to you.

**To join, call Member Support at 800-945-4355 or visit join.livongo.com/TJX/hi (registration code: TJX).**

* *ALEX is a completely voluntary resource to assist you in considering your options. Only you can decide what is best for you and your family.*

** *Well Connection is intended as a convenient alternative for common, non-emergency medical conditions but is not intended to replace an annual, in-person visit with a primary care physician or to substitute for any ongoing or regular care provided by your physician. You can also see local doctors and providers in the Blue Cross Blue Shield network if they offer live video visits through another service. Well Connection operates subject to state laws. Well Connection physicians do not prescribe Controlled Substances, and may elect not to treat certain individuals or prescribe other medications based on what is clinically appropriate. Prescribed medication is not included as part of the telehealth visit fee and is subject to your medical plan's normal prescription drug provisions. Fees vary based on the type of visit and are subject to change. Use of Well Connection is completely voluntary.*

*** *Some plans and services may require a referral from your doctor. Be sure to check your benefits or call Member Service at the number on the back of your ID card. SmartShopper is managed by Sapphire Digital, an independent company. The money you receive may be considered taxable income. Consult your tax advisor. Members with coverage under Medicaid or Medicare (including as secondary payer) are not eligible to receive incentive rewards under the SmartShopper Program. For HMO Blue plans, only network providers located in Massachusetts may qualify for rewards.*

# DENTAL PLAN

ADMINISTERED BY BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC.

## DENTAL BLUE

The following chart summarizes the benefits of the Dental Blue plan and how much members must pay for covered services. This is a "freedom of choice" plan, where you may seek services from any licensed dentist. However, to receive the greatest level of benefits, you should receive your care from a **Dental Blue participating dentist**. For more complete coverage information, please refer to your SPD or visit **bluecrossma.org/myblue**.

| DEDUCTIBLES AND MAXIMUMS | |
|---|---|
| **Calendar-Year Deductible**<br>*(January 1 through December 31)* | Group 1 & Orthodontic Services: No deductible<br>Group 2 and Group 3 Services: $50 per member; $150 per family |
| **Maximum Benefit**[9] | Groups 1, 2 and 3 Services: $1,700 per member per calendar year<br>Orthodontic: $1,250 lifetime maximum per family member |
| **SERVICES** | |
| **Group 1—Preventive Benefits**<br>**Exams, routine cleanings, X-rays, etc.** | Plan pays 100% of allowed charge. |
| **Group 2—Basic Benefits**<br>**Fillings, root canals, extractions, etc.** | You pay 25% of allowed charge after deductible. |
| **Group 3—Major Benefits**<br>**Dentures, crowns, etc.** | You pay 50% of allowed charge after deductible.<br>*It is recommended to have your dentist submit a pre-treatment estimate of costs before services are performed.* |
| **Orthodontic Services**<br>**(Through age 17 only)** | You pay 50% of allowed charge. Deductible does not apply. |

[9] *This plan includes an "Accumulated Maximum Rollover Benefit." If you qualify, this benefit allows you to roll over a portion of your unused annual benefit maximum for use in future years. This allows you to accumulate benefit dollars from a healthy year to help you pay for more expensive dental procedures in the future. Refer to your SPD for further information.*

# VISION CARE PROGRAM

ADMINISTERED BY EYEMED VISION CARE℠


The following chart summarizes the vision benefits available and how much members must pay for covered services under the Insight Plan. Once enrolled, EyeMed will send you a list of participating providers in your area as well as an ID card to present at the time of service.

| BENEFIT FEATURES | INSIGHT PLAN H | |
|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK |
| **Choice of Providers** | Members use participating EyeMed providers (LensCrafters, Pearle Vision, Target Optical, as well as a selection of independent providers) | Members use non-network providers |
| **Exam with Dilation as Necessary** | $10 copayment | Reimbursed up to $46 |
| **Exam Options** | | |
| Standard Contact Lens Fit and Follow-Up | You pay up to $40 | Not covered |
| Premium Contact Lens Fit and Follow-Up | You pay 90% of charges | Not covered |
| **Frames** | Plan pays up to $200; you pay 80% of remaining balance | Reimbursed up to $130 |
| **Standard Plastic Lenses** | | |
| Single Vision | $25 copayment | Reimbursed up to $42 |
| Bifocal | $25 copayment | Reimbursed up to $78 |
| Trifocal | $25 copayment | Reimbursed up to $130 |
| Standard Progressive Lens | $25 copayment | Reimbursed up to $140 |
| Premium Progressive Lens | $45–$70 copayment for most premium progressives[10] | Reimbursed up to $196 |
| **Lens Options** | | |
| UV Treatment | $15 copayment | Not covered |
| Tint (Solid and Gradient) | $15 copayment | Not covered |
| Standard Plastic Scratch Coating | $15 copayment | Not covered |
| Standard Polycarbonate—Adult | $40 copayment | Not covered |
| Standard Polycarbonate—Under age 26 | $40 copayment | Not covered |
| Standard Anti-Reflective Coating | $45 copayment | Not covered |
| Premium Anti-Reflective Coating | $57–$68 copayment for most premium anti-reflective coatings[10] | Not covered |
| Polarized | You pay 80% of charges | Not covered |
| Photochromatic/Transitions Plastic | $75 copayment | Not covered |
| Other Add-Ons | You pay 80% of charges | Not covered |
| **Contact Lenses** *(Contact lens allowance covers materials only)* | | |
| Conventional | Plan pays up to $130; you pay 85% of the balance | Reimbursed up to $104 |
| Disposable | Plan pays up to $130; you pay 100% of the balance | Reimbursed up to $104 |
| Medically Necessary | No cost to you | Reimbursed up to $210 |
| **Frequency** | Exam, Frames, Lenses or Contacts: Once every 12 months | |
| **Discounts**[11] | | |
| Laser Surgery | You receive a 15% discount off standard pricing or 5% off any promotional price for Lasik or PRK procedures. | Not covered |
| Additional Purchases | You receive a 40% discount on complete pair eyeglass purchases and a 15% discount on conventional contact lenses once the funded benefit has been used. | Not covered |
| Contact Lens Replacement Service | contactsdirect.com—order online for home delivery | |

[10] *For additional details, log on to eyemedvisioncare.com.*

[11] *Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.*

# LIFE INSURANCE PLANS

## BASIC LIFE INSURANCE[12]

TJX provides Basic Life Insurance at no cost to you. The following summarizes the benefits of this plan:

| | |
|---|---|
| **Coverage Amount** | 1 times your basic annual earnings, rounded up to the next multiple of $1,000 (if not already a multiple of $1,000) |
| **Maximum Benefit** | $500,000 |

## MANAGEMENT LIFE INSURANCE[12]

TJX may provide Management Life Insurance at no cost to you depending on your job level. The following summarizes the benefits of this plan:

| | |
|---|---|
| **Coverage Amount** | 1, 2 or 3 times your basic annual earnings depending on your job level, rounded up to the next multiple of $1,000 (if not already a multiple of $1,000) |
| **Maximum Benefit** | $1,500,000 |

Log in to ESS to confirm your eligibility and coverage amount.

## OPTIONAL LIFE INSURANCE[12]

You have the option of purchasing additional life insurance for yourself equal to 1, 2, 3, 4 or 5 times your annual salary, up to a maximum of $150,000 per multiple.

You may increase your Optional Life Insurance coverage by one level up to 3 times your annual salary (up to $450,000) without providing Evidence of Insurability (EOI), or Proof of Good Health. However, EOI will be required for:

- Any coverage election that increases by more than one level, or
- Any coverage election that exceeds 3 times your annual salary (up to $450,000)

## DEPENDENT LIFE INSURANCE[13]

You may elect life insurance for your spouse and/or your children through age 25 as shown below:

| | |
|---|---|
| **Spouse** | $5,000, $10,000, $15,000 or $20,000 |
| **Children** | $5,000, $10,000, $15,000 or $20,000 per child |

If you are a newly eligible Associate, you may elect up to $20,000 of coverage for your spouse and/or each eligible child. However, all other Associates may only increase coverage by one additional level during Open Enrollment or as a result of a qualifying life event.

## ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE[13]

AD&D Insurance provides extra coverage in the event of accidental death or the loss of one or more limbs or eyesight. You may elect AD&D coverage for yourself or for yourself and your eligible dependents. Eligible dependents include your spouse through age 69 and/or your children through age 25.

You have the option to purchase coverage in the following amounts: $10,000, $50,000, $100,000 or $200,000.

Refer to your SPD for additional information on the level of benefits payable in the event of a loss. In addition, please note that the coverage amount will reduce starting at age 70.

*[12] Federal law requires you to pay income tax on the premium value of life insurance coverage that is in excess of $50,000. If the amount of your coverage is greater than $50,000, the premium cost of the benefit over $50,000 will be considered a taxable benefit to you and will be added to your W-2 form as income for tax purposes.*

*[13] Two parents working for TJX cannot elect coverage for the same child. In addition, an Associate cannot be covered as both an Associate and as a dependent. Please refer to your SPD or call HR XPRESS for details.*

# DISABILITY INCOME PROTECTION

## SHORT TERM DISABILITY (STD)[14, 15]

TJX provides STD coverage at no cost to you. To be eligible to collect benefits, you must be totally disabled due to a non-work-related injury or illness (which includes childbirth) and be insured on the date you become disabled. You must also be under the regular care of a qualified physician who will be asked to regularly confirm your disability. Under this plan, benefits are paid on a weekly basis.

### HOURLY ASSOCIATES

This program provides financial protection in an amount equal to 60% of your basic weekly earnings for up to 26 weeks.

The following summarizes the payment of benefits under this plan:

- For an accident, benefits begin on the first day of disability or after all sick time is used (whichever is later).
- For an illness, which for these purposes includes childbirth, benefits begin on the eighth day of disability or after all sick time is used (whichever is later).[16]

### SALARIED ASSOCIATES/STORE MANAGEMENT/FIELD LOSS PREVENTION INVESTIGATORS/ ASSOCIATE INVESTIGATORS

This program provides financial protection for up to 13 weeks, as follows:

- 100% of basic weekly earnings for up to the first 4 weeks (and after all sick time is used[16]); then,
- 60% of basic weekly earnings for the balance of the 13-week period.

## LONG TERM DISABILITY (LTD)

You may elect LTD income protection. This program provides financial protection in an amount equal to 60% of your basic monthly earnings for a continuous disability that exceeds:

- 180 days for hourly Associates
- 90 days for salaried Associates/Store Management/Field Loss Prevention Investigators/Associate Investigators

If you are disabled before age 60, benefits will be paid to you up until age 65. If you are disabled after age 60, benefits will be paid according to a sliding schedule.

Please refer to your SPD for details regarding maximum monthly benefits, duration of benefits, reduction of benefits by other income and pre-existing condition provisions.

*[14] STD benefits run concurrently and coordinate with any applicable state disability benefits, as permitted. If you work in a state offering a state disability program, HR XPRESS will coordinate payment of the Company's STD benefits with your state disability benefits.*

*[15] Benefits are subject to income tax withholdings, as well as payroll deductions, if applicable, and are considered ordinary income for federal and state income tax purposes.*

*[16] Certain states have additional regulations around the use of sick time for leaves of absence. Contact HR XPRESS for more information.*

# NOTICE OF CREDITABLE COVERAGE

IMPORTANT NOTICE FROM THE TJX COMPANIES, INC., ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

**This notice is intended for any Medicare-eligible Associate and/or dependent who enrolls in a TJX medical plan.**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The TJX Companies, Inc., (TJX) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

## There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. TJX has determined that the prescription drug coverage offered by TJX is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current TJX coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current TJX coverage, you may enroll back into the TJX plan during the annual Open Enrollment period. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

## When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with TJX and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact HR XPRESS at 888-627-6299 for further information.

NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if your coverage through TJX changes. You also may request a copy of this notice at any time.

## For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

### For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)

### For personalized help:

- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

**Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Date: 08/01/2022 | Name of Entity/Sender: The TJX Companies, Inc. | Contact–Position/Office: HR XPRESS
Address: 300 Value Way, Marlborough, MA 01752 | Phone Number: 888-627-6299

# CONTACTS

| | |
|---|---|
| **EMPLOYEE SELF SERVICE (ESS)** | **VISIT** associates.tjx.com<br>**ACCESS** Oracle from your TJX computer |
| **HR XPRESS** | For general benefits questions and ESS navigation<br>**CALL** 888-627-6299 |
| **MEDICAL AND DENTAL** | Blue Cross Blue Shield of Massachusetts<br>**CALL** 800-859-4417<br>**VISIT** bluecrossma.org<br>**DOWNLOAD** the MYBLUE app |
| **VISION CARE PROGRAM** | EyeMed<br>**CALL** 866-800-5457<br>**VISIT** eyemedvisioncare.com<br>**DOWNLOAD** the EyeMed app |
| **HEALTH SAVINGS ACCOUNT** | HealthEquity<br>**CALL** 877-221-0836<br>**VISIT** myhealthequity.com<br>**DOWNLOAD** the HealthEquity Mobile app |
| **FLEXIBLE SPENDING ACCOUNT** | HealthEquity<br>**CALL** 877-924-3967<br>**VISIT** wageworks.com<br>**DOWNLOAD** the EZ Receipts® app |

This brochure presents only highlights of the benefit plans available to eligible Associates of The TJX Companies, Inc. The actual benefit plans are determined by the plan documents and contracts, which serve as the final authority on the plans. While every effort has been made to ensure that this brochure is accurate, if there is any difference between the information in this brochure and the legal plan documents, the plan documents govern.

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, call 1-800-859-4417. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call 1-800-859-4417 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $1,400 individual contract / $2,800 family contract. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. In-network prenatal care and preventive care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | $4,000 member / $6,000 family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $25 / visit | 40% coinsurance | Deductible applies first; a telehealth cost share may be applicable |
| | Specialist visit | $25 / visit; $25 / chiropractor visit; $25 / acupuncture visit | 40% coinsurance; 40% coinsurance / chiropractor visit; 40% coinsurance / acupuncture visit | Deductible applies first; limited to 30 chiropractor visits per calendar year; limited to 30 acupuncture visits per calendar year; a telehealth cost share may be applicable |
| | Preventive care/screening/immunization | No charge | 40% coinsurance | Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization may be required |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization may be required |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at bluecrossma.org/medication | Generic drugs | $10 / retail supply or $20 / mail order supply | Not covered | Deductible applies first; up to 30-day retail (90-day mail service) supply; maintenance medications must be filled in a 90-day supply at either Express Scripts Pharmacy℠ mail order or a CVS Pharmacy™; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs |
| | Preferred brand drugs | $35 / retail supply or $85 / mail order supply | Not covered | Deductible applies first; up to 30-day retail (90-day mail service) supply; maintenance medications must be filled in a 90-day supply at either Express Scripts Pharmacy mail order or a CVS Pharmacy; most brand-name drugs are covered based on generic equivalent, member cost is generic copayment plus amount in excess of generic cost; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs |
| | Non-preferred brand drugs | $50 / retail supply or $120 / mail order supply | Not covered | |
| | Specialty drugs | Applicable cost share (generic, preferred, non-preferred) | Not covered | Deductible applies first; when obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; most brand-name drugs are covered based on generic equivalent, member cost is generic copayment plus amount in excess of generic cost; pre-authorization 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) | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If you need immediate medical attention | Emergency room care | $150 / visit | $150 / visit | Deductible applies first; copayment waived if admitted or for observation stay |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Deductible applies first |
| | Urgent care | $25 / visit | 40% coinsurance | Deductible applies first; a telehealth cost share may be applicable |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $25 / visit | 40% coinsurance | Deductible applies first; a telehealth cost share may be applicable; pre-authorization required for certain services |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If you are pregnant | Office visits | No charge for prenatal care; 20% coinsurance for postnatal care | 40% coinsurance | Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| | Rehabilitation services | $25 / visit for outpatient services; 20% coinsurance for inpatient services | 40% coinsurance for outpatient services; 40% coinsurance for inpatient services | Deductible applies first; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services |
| | Habilitation services | $25 / visit | 40% coinsurance | Deductible applies first; outpatient rehabilitation therapy coverage limits apply; copayment and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Deductible applies first; limited to 100 days per calendar year; pre-authorization required |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Deductible applies first; in-network cost share waived for one breast pump per birth |
| | Hospice services | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | No charge for members with a cleft palate / cleft lip condition | 40% coinsurance for members with a cleft palate / cleft lip condition | Deductible applies first for out-of-network; limited to members under age 18 |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Children's eye exam | • Cosmetic surgery | • Long-term care |
| • Children's glasses | • Dental care (Adult) | • Routine eye care - adult |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture (30 visits per calendar year) | • Infertility treatment (cryopreservation is limited to $10,000 lifetime maximum for non-medically necessary treatment for members under age 44) | • Routine foot care (only for patients with systemic circulatory disease) |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs ($50 per calendar year per policy, up to a $100 lifetime maximum) |
| • Chiropractic care (30 visits per calendar year) | • Private-duty nursing (40 visits per calendar year) | |
| • Hearing aids ($2,000 per ear every 36 months for members age 21 or younger) | | |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-859-4417 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Does this plan provide Minimum Essential Coverage?** Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

## About these Coverage Examples:

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

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $1,400 |
| ■ **Delivery fee** coinsurance | 20% |
| ■ **Facility fee** coinsurance | 20% |
| ■ Diagnostic tests coinsurance | 20% |

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

| Total Example Cost | $12,700 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $10 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $3,870 |

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $1,400 |
| ■ Specialist visit copay | $25 |
| ■ **Primary care visit** copay | $25 |
| ■ Diagnostic tests coinsurance | 20% |

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| Total Example Cost | $5,600 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $1,000 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $2,430 |

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $1,400 |
| ■ Specialist visit copay | $25 |
| ■ **Emergency room** copay | $150 |
| ■ **Ambulance services** coinsurance | 20% |

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

| Total Example Cost | $2,800 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,700 |

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

MASSACHUSETTS

# MCC COMPLIANCE

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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55-0647 (6/21)

MASSACHUSETTS

# NONDISCRIMINATION NOTICE

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**.

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**; 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**.


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55-1487 (6/21)

# 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 Idantitifkasyon 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/ةيبر:**

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

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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 नि:शुल्क 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 કૉલ 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 شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

**Lao/ພາສາລາວ:** ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. 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'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).


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55-1493 (6/21)

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, call 1-800-859-4417. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call 1-800-859-4417 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $325 member / $650 family in-network; $650 member / $1,300 family out-of-network. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. In-network preventive and prenatal care, most office visits, therapy visits, mental health visits, prescription drugs; emergency room, emergency transportation. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | $2,500 member / $5,000 family in-network; $3,750 member / $7,500 family out-of-network. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $25 / visit | 40% coinsurance | Deductible applies first for out-of-network; a telehealth cost share may be applicable |
| | Specialist visit | $25 / visit; $25 / chiropractor visit; $25 / acupuncture visit | 40% coinsurance; 40% coinsurance / chiropractor visit; 40% coinsurance / acupuncture visit | Deductible applies first for out-of-network; limited to 30 chiropractor visits per calendar year; limited to 30 acupuncture visits per calendar year; a telehealth cost share may be applicable |
| | Preventive care/screening/immunization | No charge | 40% coinsurance | Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization may be required |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization may be required |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at bluecrossma.org/medication | Generic drugs | $10 / retail supply or $20 / mail order supply | Not covered | Up to 30-day retail (90-day mail order) supply; maintenance medications must be filled in a 90-day supply at either Express Scripts Pharmacy℠ mail order or a CVS Pharmacy™; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs |
| | Preferred brand drugs | $35 / retail supply or $85 / mail order supply | Not covered | Up to 30-day retail (90-day mail order) supply; maintenance medications must be filled in a 90-day supply at either Express Scripts Pharmacy mail order or a CVS Pharmacy; most brand-name drugs are covered based on generic equivalent, member cost is generic copayment plus amount in excess of generic cost; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs |
| | Non-preferred brand drugs | $50 / retail supply or $120 / mail order supply | Not covered | |
| | Specialty drugs | Applicable cost share (generic, preferred, non-preferred) | Not covered | When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; most brand-name drugs are covered based on generic equivalent, member cost is generic copayment plus amount in excess of generic cost; pre-authorization 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) | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If you need immediate medical attention | Emergency room care | $150 / visit; deductible does not apply | $150 / visit; deductible does not apply | Copayment waived if admitted or for observation stay |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | $25 / visit | 40% coinsurance | Deductible applies first for out-of-network; a telehealth cost share may be applicable |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $25 / visit | 40% coinsurance | Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization required for certain services |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If you are pregnant | Office visits | $25 for first prenatal care visit, then no charge; 20% coinsurance for postnatal care | 40% coinsurance | Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| | Rehabilitation services | $25 / visit for outpatient services; 20% coinsurance / for inpatient services | 40% coinsurance for outpatient services; 40% coinsurance / for inpatient services | Deductible applies first except for in-network outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services |
| | Habilitation services | $25 / visit | 40% coinsurance | Deductible applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Deductible applies first; limited to 100 days per calendar year; pre-authorization required |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Deductible applies first; in-network cost share waived for one breast pump per birth |
| | Hospice services | 20% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | No charge for members with a cleft palate / cleft lip condition | 40% coinsurance for members with a cleft palate / cleft lip condition | Deductible applies first for out-of-network; limited to members under age 18 |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Children's eye exam | • Cosmetic surgery | • Long-term care |
| • Children's glasses | • Dental care (Adult) | • Routine eye care - adult |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture (30 visits per calendar year) | • Infertility treatment (cryopreservation is limited to $10,000 lifetime maximum for non-medically necessary treatment for members under age 44) | • Private-duty nursing (40 visits per calendar year) |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care (only for patients with systemic circulatory disease) |
| • Chiropractic care (30 visits per calendar year) | | • Weight loss programs ($50 per calendar year per policy, up to a $100 lifetime maximum) |
| • Hearing aids ($2,000 per ear every 36 months for members age 21 or younger) | | |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-859-4417 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Does this plan provide Minimum Essential Coverage?** Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

## About these Coverage Examples:

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

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $325 |
| ■ **Delivery** fee coinsurance | 20% |
| ■ **Facility fee** coinsurance | 20% |
| ■ Diagnostic tests coinsurance | 20% |

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

| Total Example Cost | $12,700 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $2,560 |

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $325 |
| ■ Specialist visit copay | $25 |
| ■ **Primary care visit** copay | $25 |
| ■ Diagnostic tests coinsurance | 20% |

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| Total Example Cost | $5,600 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $1,300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $1,420 |

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $325 |
| ■ Specialist visit copay | $25 |
| ■ **Emergency room** copay | $150 |
| ■ **Ambulance services** coinsurance | 20% |

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

| Total Example Cost | $2,800 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $500 |

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

MASSACHUSETTS

# MCC COMPLIANCE

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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55-0647 (6/21)

MASSACHUSETTS

# NONDISCRIMINATION NOTICE

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**.

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**; 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**.


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55-1487 (6/21)

# 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 Idantitifkasyon 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/ةيبر:**

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

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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 नि:शुल्क 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 કૉલ 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 شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

**Lao/ພາສາລາວ:** ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. 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'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).


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55-1493 (6/21)

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, call 1-800-859-4417. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call 1-800-859-4417 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $600 member / $1,200 family in-network; $1,000 member / $2,000 family out-of-network. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. In-network preventive and prenatal care, prescription drugs; emergency transportation. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | $3,000 member / $6,000 family in-network; $6,000 member / $12,000 family out-of-network. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 30% coinsurance | 40% coinsurance | Deductible applies first; a telehealth cost share may be applicable |
| | Specialist visit | 30% coinsurance; 30% coinsurance / chiropractor visit; 30% coinsurance / acupuncture visit | 40% coinsurance; 40% coinsurance / chiropractor visit; 40% coinsurance / acupuncture visit | Deductible applies first; limited to 30 chiropractor visits per calendar year; limited to 30 acupuncture visits per calendar year; a telehealth cost share may be applicable |
| | Preventive care/screening/immunization | No charge | 40% coinsurance | Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization may be required |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization may be required |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at bluecrossma.org/medication | Generic drugs | $10 / retail supply or $20 / mail order supply | Not covered | Up to 30-day retail (90-day mail order) supply; maintenance medications must be filled in a 90-day supply at either Express Scripts Pharmacy℠ mail order or a CVS Pharmacy™; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs |
| | Preferred brand drugs | $35 / retail supply or $85 / mail order supply | Not covered | Up to 30-day retail (90-day mail order) supply; maintenance medications must be filled in a 90-day supply at either Express Scripts Pharmacy mail order or a CVS Pharmacy; most brand-name drugs are covered based on generic equivalent, member cost is generic copayment plus amount in excess of generic cost; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs |
| | Non-preferred brand drugs | $50 / retail supply or $120 / mail order supply | Not covered | |
| | Specialty drugs | Applicable cost share (generic, preferred, non-preferred) | Not covered | When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; most brand-name drugs are covered based on generic equivalent, member cost is generic copayment plus amount in excess of generic cost; pre-authorization 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) | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| | Physician/surgeon fees | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If you need immediate medical attention | Emergency room care | 30% coinsurance | 30% coinsurance | In-network deductible applies first for in-network and out-of-network services |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None |
| | Urgent care | 30% coinsurance | 40% coinsurance | Deductible applies first; a telehealth cost share may be applicable |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| | Physician/surgeon fees | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 30% coinsurance | 40% coinsurance | Deductible applies first; a telehealth cost share may be applicable; pre-authorization required for certain services |
| | Inpatient services | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If you are pregnant | Office visits | No charge for prenatal care; 30% coinsurance for postnatal care | 40% coinsurance | Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable |
| | Childbirth/delivery professional services | 30% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required |
| | Rehabilitation services | 30% coinsurance for outpatient services; 30% coinsurance for inpatient services | 40% coinsurance for outpatient services; 40% coinsurance for inpatient services | Deductible applies first; limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services |
| | Habilitation services | 30% coinsurance | 40% coinsurance | Deductible applies first; in-network in-network cost share waived for early intervention services for eligible children; a telehealth cost share may be applicable |
| | Skilled nursing care | 30% coinsurance | 40% coinsurance | Deductible applies first; limited to 100 days per calendar year; pre-authorization required |
| | Durable medical equipment | 30% coinsurance | 40% coinsurance | Deductible applies first; in-network cost share waived for one breast pump per birth |
| | Hospice services | 30% coinsurance | 40% coinsurance | Deductible applies first; pre-authorization required for certain services |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | No charge for members with a cleft palate / cleft lip condition | 40% coinsurance for members with a cleft palate / cleft lip condition | Deductible applies first for out-of-network; limited to members under age 18 |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Children's eye exam | • Cosmetic surgery | • Long-term care |
| • Children's glasses | • Dental care (Adult) | • Routine eye care - adult |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture (30 visits per calendar year) | • Infertility treatment (cryopreservation is limited to $10,000 lifetime maximum for non-medically necessary treatment for members under age 44) | • Private-duty nursing (40 visits per calendar year) |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care (only for patients with systemic circulatory disease) |
| • Chiropractic care (30 visits per calendar year) | | • Weight loss programs ($50 per calendar year per policy, up to a $100 lifetime maximum) |
| • Hearing aids ($2,000 per ear every 36 months for members age 21 or younger) | | |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-859-4417 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Does this plan provide Minimum Essential Coverage?** Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

## About these Coverage Examples:

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

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $600 |
| ■ **Delivery** fee coinsurance | 30% |
| ■ **Facility fee** coinsurance | 30% |
| ■ Diagnostic tests coinsurance | 30% |

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

| Total Example Cost | $12,700 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $600 |
| Copayments | $0 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $3,060 |

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $600 |
| ■ Specialist visit coinsurance | 30% |
| ■ **Primary care visit** coinsurance | 30% |
| ■ Diagnostic tests coinsurance | 30% |

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| Total Example Cost | $5,600 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $600 |
| Copayments | $1,100 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $1,920 |

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

| | |
|---|---|
| ■ **The** plan's overall deductible | $600 |
| ■ Specialist visit coinsurance | 30% |
| ■ **Emergency room** coinsurance | 30% |
| ■ **Ambulance services** coinsurance | 30% |

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

| Total Example Cost | $2,800 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $600 |
| Copayments | $10 |
| Coinsurance | $800 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,410 |

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

MASSACHUSETTS

# MCC COMPLIANCE

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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55-0647 (6/21)

MASSACHUSETTS

# NONDISCRIMINATION NOTICE

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**.

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**; 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**.


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55-1487 (6/21)

# 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 Idantitifkasyon 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/ةيبر:**

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

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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 नि:शुल्क 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 કૉલ 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 شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

**Lao/ພາສາລາວ:** ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. 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'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).


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