LOWER PIONEER VALLEY EDUCATIONAL COLLABORATIVE

BENEFITS INFORMATION

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Lower Pioneer Valley Educational Collaborative

SVRHT INSURANCE RATES

no changes from fy24 **FY25** **Plan Year: 7/1/2024 - 6/30/2025**

HEALTH INSURANCE RATES

PRODUCT	TYPE	COVERAGE	MONTHLY PREMIUM	ACTIVE EMPLOYEES: Collaborative Monthly Share	ACTIVE EMPLOYEES: Employee Monthly Share	ACTIVE EMPLOYEES: Employee Share Per Pay Period	ACTIVE EMPLOYEES: Employee Share Per Pay Period	RETIREES: Non-Medicare Eligible Monthly Share	INACTIVE: COBRA Rates
			100%	70%	30%	26	22	50%	
Network Blue	**HMO**	Single	$930.00	$651.00	$279.00	$128.77	$152.18	$465.00	$948.60
Standard Plan Group #00-2238438		Family	$2,302.00	$1,611.40	$690.60	$318.74	$376.69	$1,151.00	$2,348.04
Network Blue	**HMO**	Single	$903.00	$632.10	$270.90	$125.03	$147.76	$451.50	$921.06
Deductible Plan Group #00-4056369		Family	$2,242.00	$1,569.40	$672.60	$310.43	$366.87	$1,121.00	$2,286.84
Health New England	**HMO**	Single	$814.00	$569.80	$244.20	$112.71	$133.20	$407.00	$830.28
Standard Plan Group #S03042-0016		Family	$2,027.00	$1,418.90	$608.10	$280.66	$331.69	$1,013.50	$2,067.54
Health New England	**HMO**	Single	$786.00	$550.20	$235.80	$108.83	$128.62	$393.00	$801.72
Deductible Plan Group #S03042-0026		Family	$1,961.00	$1,372.70	$588.30	$271.52	$320.89	$980.50	$2,000.22
HARVARD PILGRIM (FORMERLY TUFTS)	**HMO**	Single	$941.00	$658.70	$282.30	$130.29	$153.98	$470.50	$959.82
Standard Plan Group #1777210015		Family	$2,352.00	$1,646.40	$705.60	$325.66	$384.87	$1,176.00	$2,399.04
HARVARD PILGRIM (FORMERLY TUFTS)	**HMO**	Single	$856.00	$599.20	$256.80	$118.52	$140.07	$428.00	$873.12
Deductible Plan Group #1777210016		Family	$2,135.00	$1,494.50	$640.50	$295.62	$349.36	$1,067.50	$2,177.70
Blue Care Elect Preferred -	**PPO**	Single	$1,586.00	$1,110.20	$475.80	$219.60	$259.53	$793.00	$1,617.72
Standard Plan Group #00-2345370		Family	$3,451.00	$2,415.70	$1,035.30	$477.83	$564.71	$1,725.50	$3,520.02

**see below note for hourly employees

DENTAL INSURANCE RATES

no change from FY24

PRODUCT	TYPE	COVERAGE	MONTHLY PREMIUM	ACTIVE EMPLOYEES: Employee Monthly Share	ACTIVE EMPLOYEES: Employee Share Per Pay Period	ACTIVE EMPLOYEES: * Employee Share Per Pay Period	RETIREES: Non-Medicare Eligible Monthly Share
			100%	100%	26	22	100%
Dental Blue Freedom	**OPTION 1**	Single	$48.24	$48.24	$22.26	$26.31	$48.24
100/50/50%, $2,000 max, $25/$75 deductible		Family	$130.11	$130.11	$60.05	$70.97	$130.11
Dental Blue Freedom	**OPTION 2**	Single	$55.20	$55.20	$25.48	$30.11	$55.20
100/80/50%, $2,000 max, $50/$150 deductible		Family	$148.93	$148.93	$68.74	$81.23	$148.93

VISION INSURANCE RATES

no change from FY24

PRODUCT	TYPE	COVERAGE	MONTHLY PREMIUM	ACTIVE EMPLOYEES: Employee Monthly Share	ACTIVE EMPLOYEES: Employee Share Per Pay Period	ACTIVE EMPLOYEES: * Employee Share Per Pay Period	RETIREES: Non-Medicare Eligible Monthly Share
			100%	100%	26	22	100%
Blue 20/20 Access Network		Single	$7.82	$7.82	$3.61	$4.27	$7.82
Group Plan #20288		Employee+Spouse only	$13.30	$13.30	$6.14	$7.25	$13.30
		Empl+child/children(no spouse)	$13.69	$13.69	$6.32	$7.47	$13.69
		Family	$21.51	$21.51	$9.93	$11.73	$21.51

*** New enrollments/coverage changes for 22 week/10-month paid employees:** 7/1/2023 enrollment

A check **must** be submitted payable to LPVEC for the cost of the employee share premiums for the months of July and August with your enrollment form.
Regular deductions will begin in the month of September.

**** For hourly employees, your first check in September may not have enough pay to cover your regular biweekly insurance premium.**
If that is the case, we will be making up the amount not paid/still owed in the next two paychecks.

SVRHT Plan Benefit Comparison

Effective 7-1-24

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.

	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**HMO**
Deductible	None	None	$400 Individual $800 Family	None	None
Out-of-Pocket (OOP) Maximum - *Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year* ***(July 1 to June 30).***	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $3,000 per member	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family
Lifetime Benefit Maximum	None	None	None	None	None
INPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services)	$500 copay	$500 copay	20% coinsurance* Processes at in-network rate for emergency/accident admissions	$500 copay	$500 copay
Physician Services	Nothing	Nothing	20% coinsurance* Processes at in-network rate for emergency/accident admissions	Nothing	Nothing
Skilled Nursing Facility	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum combined with out of network days	20% coinsurance* to 100 days per calendar year benefit maximum, combined with in-network days	$0 copay for up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing up to 100 days per plan year
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% coinsurance* to 60 days per calendar year benefit maximum	$0 copay for up to 100 days per calendar year, combined with skilled care.	Nothing up to 60 days per plan year
OUTPATIENT HOSPITAL	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Emergency Room Visits for Emergency or Accident Care	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay, (waived if admitted)	$100 copay, (waived if admitted)
Emergency Room Visits for Medical Care	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay, waived if admitted	$100 copay, waived if admitted

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	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**HMO**
Surgery	$150 copay	$150 copay	20% coinsurance*	$150 copay	$150 copay
Radiation and Chemotherapy	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Diagnostic X-ray and Lab	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine Colonoscopy *(without symptoms)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
High Cost Radiology (MRI, CT & PET)	$100 copay* - copay waived if received at non-hospital facilities	$100 copay* - copay waived if received at non-hospital facility	20% coinsurance* No deductible for OON	Outpatient hospital based services $100 copay; $0 for non-hospital based services	$100 copay*
Hemodialysis	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Physical Therapy	$20 copay to 60 visits per calendar year	$20 copay to 100 visits per calendar year	20% coinsurance* to 100 visits per calendar year	$20 copay (60 visits per calendar year for PT and OT)	$35 co-pay - (60 visits per calendar year for PT and OT)
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Surgery	$20 PCP Office $35 Specialists Office	$20 PCP Office $35 Specialists Office	20% coinsurance*	$20 PCP Office $35 Specialists Office	No charge
Adult Preventative Exam *(includes preventative lab*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	$20 copay	$20 copay	20% coinsurance*	$20 copay	$20 copay
Well Child Care *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine GYN Exam *(one per calendar year, includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine Mammogram	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine Vision Exam	$0 copay (once every 12 months)	$0 copay (once per calendar year)	20% coinsurance after deductible(once per calendar year)	$0 copay (once per calendar year)	$20 copay (once per plan year)
Specialist Office Visit	$35 copay	$35 copay	20% coinsurance*	$35 copay	$35 copay
OTHER OUTPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Visiting Nurse Home Health Care	Nothing (Includes Hospice Care)	Nothing	20% coinsurance*	Nothing	Nothing
Durable Medical Equipment	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit*	40% coinsurance after deductible	Member pays 20%, plan pays 80% with no limit	Member pays 30%, plan pays 70% with no limit

SVRHT Plan Benefit Comparison

Effective 7-1-24

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail.
Should any questions arise, the certificate(s) & riders will govern.

	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	HARVARD PILGRIM
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**HMO**
Ambulance	Nothing (for emergency or medically necessary transport)	Nothing (for emergency or medically necessary transport)	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	$25 co-pay per member per day (included Chair Van services)	Nothing (for emergency or medically necessary transport)
Routine Pediatric Dental (under age 12)	Nothing (covered services each six months)	All charges	All charges	Not covered	$20 copay up to age 13
Chiropractor Visits	$20 copay per visit(up to 12 visits per calendar year)	$20 copay per visit (up to 12 visits per calendar year)	20% coinsurance (up to 12 visits per calendar year)	$20 copay per visit (up to12 visits per calendar year)	$20 copay per visit (up to 12 visits per year)
Prescription Drugs	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay CVS Caremark is the PBM	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay CVS Caremark is the PBM	OON NOT COVERED	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay OptumRx is the PBM for retail and mail order.	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay Optum is the PBM
Weight Loss	Up to $150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to $150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to $150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals, WeightWatchers®	Up to $200/ind and $400/fam reimbursement per calendar year towards fitness club membership, Aerobic and Wellness classes, Personal Trainer fees and school and town sports registration fees, wellness and fitness apps, nutrition apps, mindfulless apps, bike shares and Weight Watchers® program.	Discount and Savings programs available such as Eat Right Now, Inside Tracker, Daily Burn, ProSourceFit, and more
Fitness Benefit	Up to $150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs; or virtual /online fitness memberships,subscriptions , programs providing the same. Now includes home gym equipment	Up to $150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs; or virtual /online fitness memberships,subscriptions , programs providing the same. Now includes home gym equipment	Up to $150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs; or virtual /online fitness memberships,subscriptions , programs providing the same. Now includes home gym equipment		Up to $150 fitness reimbursement per household, per plan year

***After Deductible**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see http://www.scantichealth.org/health-plans.html. 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 **1-800-486-1136** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
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?	For medical benefits, $2,000 member / $4,000 family; and for prescription drug benefits, $3,000 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$20 / visit	Not covered	A telehealth cost share may be applicable
	Specialist visit	$35 / visit; $20 / chiropractor visit; $35 / acupuncture visit	Not covered	Limited to 12 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; 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)	No charge	Not covered	Pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$100 for hospitals; No charge for other providers	Not covered	Copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or $50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$50 / retail supply or $110 / designated retail or mail service 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; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	Not covered	Pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$35 / visit	$35 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable

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 a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	Not covered	Pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	A telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$500 / admission	Not covered	Pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for 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	No charge	Not covered	
	Childbirth/delivery facility services	$500 / admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-authorization required for certain services
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	Not covered	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	$20 / visit	Not covered	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; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Cost share waived for one breast pump per birth, including supplies
	Hospice services	No charge	Not covered	Pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care (12 visits per calendar year)
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 12 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-486-1136 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	$0
■Delivery fee copay	$0
■Facility fee copay	$500
■Diagnostic tests copay	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

■The plan's overall deductible	$0
■Specialist visit copay	$35
■Primary care visit copay	$20
■Diagnostic tests copay	$0

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

■The plan's overall deductible	$0
■Specialist visit copay	$35
■Emergency room copay	$100
■Ambulance services copay	$0

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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.

001652563

55-0647 (6/23)

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**.

001651238

55-1487 (6/23)

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/عربية:

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**).

001651831
55-1493 (6/23)

Scantic Valley Regional Health Trust - Exclusive (FI- with Deductible)

HMO Benefit Chart

July 1, 2024

This chart provides a summary of key services offered by your Plan. Your Summary Plan Description (SPD) has a full description of your Plan's benefits and provisions. If any terms in this summary differ from those in your SPD, the terms of the SPD apply.

Note about Prior Approval:
Some services may require Prior Approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan HNE Providers
Deductible per Calendar Year: You must pay this amount for Covered Services before Health New England will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.	$250 per Individual / $750 per Family
In-Plan Out-of-Pocket Maximum: The most you pay for Cost Sharing on Essential Health Benefits during a Calendar Year before your Plan begins to pay 100% of the Allowed Amount.	**Medical:** $2,000 per Individual / $4,000 per Family
	Pharmacy: $3,000 per Individual / $6,000 per Family

Benefit	**Your Cost In-Plan HNE Providers**
Inpatient Care	
Acute Hospital Care	$500 Copay per admission after Deductible
Skilled Nursing Facility and Inpatient Rehabilitation † (Limited to 100 days per Calendar Year)	$0 after Deductible
Preventive Care	
Adult Routine Exams (Members age 18 and older)	$0
Well Child Care	$0
Child and Adult Routine Immunizations	$0
Routine Prenatal & Postpartum Care	$0
Routine Eye Exams (Limited to 1 per Calendar Year)	$0
Annual Gynecological Exams	$0
Routine Mammograms (Limited to 1 per Calendar Year)	$0

Benefit	Your Cost In-Plan HNE Providers
Screening Colonoscopy or Sigmoidoscopy (Limited to 1 every 5 Years)	$0
Nutritional Counseling (Limited to 4 visits per Calendar Year)	$0
Outpatient Care	
Primary Care Office Visit (Non-Routine)	$20 Copay per visit
Specialist Care Office Visit	$35 Copay per visit
Second Opinions	$35 Copay per visit
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$20 Copay per visit
Diabetic-Related Items:	
• Outpatient Services (Some services require Prior Approval.)	$35 Copay per visit
• Lab Services	$0 after Deductible
• Radiological Services	$0 after Deductible
• Durable Medical Equipment (some DME items require Prior Approval)	20% Coinsurance after Deductible
• Individual Diabetic Education	$35 Copay per visit
• Group Diabetic Education	$20 Copay per session
Emergency Room Care (Copay waived if admitted directly from the ER.)	$100 Copay per visit after Deductible
Diagnostic Testing (some services, including, but not limited to, sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies, are covered under the Surgical Services and Procedures in an Outpatient Facility benefit)	$35 Copay
Sleep Study†	$0 after Deductible
Lab Services	$0 after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms†	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging† (Nuclear Cardiac Imaging requires Prior Approval in all outpatient settings, including outpatient facilities and doctor's offices)	
• Outpatient hospital based services	$100 Copay after Deductible
• Outpatient non-hospital based services	$0 after Deductible

Benefit	Your Cost In-Plan HNE Providers
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per Calendar Year for physical or occupational therapy. The Calendar year limit does not apply to services that are part of a home health plan. The limit also does not apply when services are provided to treat autism spectrum disorder.) Services that are part of a home health plan and services provided to treat autism spectrum disorder require Prior Approval.)	$20 Copay per visit per treatment type
Day Rehabilitation Program (Limited to 15 full day or ½ day sessions per condition per lifetime)	$25 Copay for 1 day or 1/2 day
Early Intervention Services	$35 Copay
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder	$0
Surgical Services and Procedures in an Outpatient Facility	
• In a Doctor's Office	$35 Copay
• In all other settings	$150 Copay after Deductible
Allergy Testing and Treatment	$35 Copay per visit
Allergy Injections	$0
Infertility Services	
Some infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	
• Office Visit	$35 Copay per visit
• Lab Test	$0 after Deductible
• Inpatient Care†	$500 Copay per admission after Deductible
Maternity Care	
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)	$500 Copay after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions	
• In a Doctor's Office	$35 Copay per visit
• In an Emergency Room (Copay waived if admitted directly from the ER)	$100 Copay per visit after Deductible
Other Services	
Home Health Care†	$0 after Deductible
Hospice Services†	$0
Durable Medical Equipment (some DME items require Prior Approval)	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan HNE Providers
Prosthetic Devices†	20% Coinsurance after Deductible
Ambulance and Transportation Services	$25 Copay per day
Kidney Dialysis	$0
Nutritional Support † (not covered without Prior Approval)	$0
Cardiac Rehabilitation	$35 Copay per visit
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. Limited to 1 prosthesis per Calendar Year)	$0
Speech, Hearing, and Language Disorders† (Prior Approval is required for speech therapy services after the initial evaluation.)	$20 Copay per visit
Hearing Aids† (Covered with Prior Approval for Members age 21 and under. The Plan covers the cost of one hearing aid per hearing-impaired ear, every 36 months, up to maximum of $2,000 for each hearing aid.)	$0 up to $2,000 per device per ear (you are responsible for all costs beyond maximum)
Human Organ Transplants and Bone Marrow Transplants†	$500 Copay per admission after Deductible
Chiropractic Care	
Chiropractic Care (Limited to 12 visits per Calendar Year. After your first visit to an In-Plan Provider your chiropractor must get authorization for services to be covered from OptumHealth Solutions. OptumHealth Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition.)	$20 Copay
Wellness Services	
The plan reimburses for certain fitness and wellness activities, including acupuncture and hypnosis related to weight loss, Weight Watchers®, gym membership, personal training, golf, ski tickets, fitness equipment, farm shares, wellness and fitness apps, nutrition apps, mindfulness apps, bike shares and more. The $400 payment for a family can be split among family members of the plan. The maximum for each member on the plan is $200.	$200 per Individual / $400 per Family
Acupuncture (limited to 12 visits per calendar year)	$20 Copay
Behavioral Health (Includes Mental Health and Substance Use Disorder)	
Outpatient Services†	$20 Copay per visit
Inpatient Services†	$500 Copay per admission after Deductible

Prescription Drugs *(certain drug require Prior Approval).* Your prescription Drug benefit is based on the Health New England (HNE) Formulary. Please call Member Services or visit healthnewengland.org for a copy of the HNE Formulary.	
At an Retail Pharmacy (up to a 30 day supply)	
Generic Drugs	$10 Copay
Formulary Drugs	$25 Copay
Non-Formulary Drugs	$50 Copay
Through Mail Order (up to a 90 day supply of maintenance medication)	
Generic Drugs	$20 Copay
Formulary Drugs	$50 Copay
Non-Formulary Drugs	$110 Copay

Health New England complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health New England cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Health New England cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0 (TTY: 711). Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0 (TTY: 711). Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0 (TTY: 711).

Harvard Pilgrim Health Care

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
The Harvard Pilgrim HMO

Coverage Period: 07/01/2024 — 06/30/2025
Coverage for: Individual + Family | Plan Type: HMO

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, **www.harvardpilgrim.org/LGsampleEOC**. 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 **www.healthcare.gov/sbc-glossary** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0 Benefits are administered on a Plan Year basis.	See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	Yes: **durable medical equipment**, **emergency room care**, **emergency medical transportation**, prescription drugs, outpatient mental health services, **preventive care**, **provider** office visits, **rehabilitation services**, **habilitation services**, routine eye exams, are covered before you meet your **deductibles**.	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?	$2,000 member/ $4,000 family Separate **out-of-pocket limit** applies to Pharmacy, see "If you need drugs to treat your illness or condition".	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 limit** until the overall family **out-of-pocket limit** has been met.

Important Questions	Answers	Why This Matters
What is not included in the out–of–pocket limit?	Prescription drugs, 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 **https://www.harvardpilgrim.org/public/find-a-provider** or call **1-888-333-4742** 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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	Level 1: $20 copay/visit	Not covered	None
	Specialist visit	Level 1: $20 copay/visit Level 2: $35 copay/visit	Not covered	None
	Preventive care/ screening/ immunization	No charge	Not covered	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)	X-rays: No charge Laboratory: No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay/procedure	Not covered	Cost sharing may vary for certain imaging services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/ 2024Premium3T**.	Generic drugs	30-Day Retail Tier 1: $10 copay/prescription; deductible does not apply 90-Day Mail Tier 1: $20 copay/prescription; deductible does not apply	Not covered	You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area. Prescription drug Out-of-Pocket Maximum: $3,000 member/ $6,000 family
	Preferred brand drugs	30-Day Retail Tier 2: $25 copay/prescription; deductible does not apply 90-Day Mail Tier 2: $50 copay/prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 3: $50 copay/prescription; deductible does not apply 90-Day Mail Tier 3: $110 copay/prescription; deductible does not apply	Not covered	
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3	Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit		None
	Emergency medical transportation	No charge		None
	Urgent care	Urgent care center: $35 copay/visit	Urgent care center: Not covered	Non-participating providers only covered outside the service area. Cost sharing may vary based on location.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admit	Not covered	None
	Physician/surgeon fee	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	Not covered	None
	Inpatient services	$500 copay/admit	Not covered	
If you are pregnant	Office visits	$20 copay/visit	Not covered	Cost sharing does not apply for preventive services (such as routine prenatal visits).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$500 copay/admit	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services Habilitation services	Physical Therapy: $35 copay/visit Occupational Therapy: $35 copay/visit Speech Therapy: $35 copay/visit	Not covered	Occupational & physical therapy – 60 combined visits /Plan Year
	Skilled nursing care	No charge	Not covered	100 days/Plan Year
	Durable medical equipment	30% coinsurance	Not covered	Wigs – $350/Plan Year
	Hospice services	No charge	Not covered	For inpatient see "If you have a hospital stay"

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$20 copay/visit	Not covered	1 exam/Plan Year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up – Up to age of 13	$20 copay/visit	Not covered	2 exams/Plan Year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (except for diabetes or systemic circulatory diseases)
- Services that are not Medically Necessary
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care - 12 visits/Plan Year
- Hearing Aids - $2,000/aid every 36 months, for each impaired ear up to age 22
- Infertility Treatment
- Routine eye care (Adult) – 1 exam/Plan Year

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 Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, or the Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, at **1-877-267-2323 x61565** or **www.cciio.cms.gov**, or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call **1-888-333-4742**. 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**.

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, contact:

HPHC Member Appeals-Member Services Department
Harvard Pilgrim Health Care, Inc.
1 Wellness Way
Canton, MA 02021-1166
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
http://www.hcfama.org/helpline

Does this plan meet the Minimum Value Standard? 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**.

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**.

Language Access Services:

Para obtener asistencia en Español, llame al **1–888–333–4742**.
如果需要中文的帮助, 请拨打这个号码 **1–888–333–4742**.
De assistência em Português, por favor ligue **1–888–333–4742**.

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 (deductible, copayment and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	$0	■ **The plan's overall deductible**	$0	■ **The plan's overall deductible**	$0
■ **Specialist copayment**	$35	■ **Specialist copayment**	$35	■ **Specialist copayment**	$35
■ **Hospital (facility) copayment**	$500	■ **Hospital (facility) copayment**	$500	■ **Hospital (facility) copayment**	$500
■ **Other**	$0	■ **Other**	$0	■ **Other**	$0
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care*)		Primary care physician office visits (*including disease education*)		Emergency room care (*including medical supplies*)	
Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)		Diagnostic test (*x-ray*)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (*crutches*)	
Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)		Rehabilitation services (*physical therapy*)	
Specialist visit (*anesthesia*)					
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$600	Copayments	$1,100	Copayments	$300
Coinsurance	$0	Coinsurance	$0	Coinsurance	$70
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$0	Limits or exclusions	$0	Limits or exclusions	$0
The total Peg would pay is	**$600**	**The total Joe would pay is**	**$1,100**	**The total Mia would pay is**	**$370**

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

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اَللُّغة **اَلعربية** ، خَدَمات اَلمُساعَدة اَللُّغوية مُتَوفرة لك مَجانا. ً **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

HPHC:

- 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, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer 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, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see **www.scantichealth.org/health-plans.html**. 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 **1-800-486-1136** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 member / $750 family in-network; $400 member / $800 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, prescription drugs.	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?	For medical benefits, $2,000 member / $4,000 family in-network; $3,000 member out-of-network; and for prescription drug benefits, $3,000 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	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group or by a physician assistant or nurse practitioner designated as primary care; a telehealth cost share may be applicable
	Specialist visit	$35 / visit; $20 / chiropractor visit; $35 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 12 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% 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)	No charge	20% coinsurance	Deductible applies first; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	$100 for hospitals; No charge for other providers	20% coinsurance	Deductible applies first; copayment applies per category of test / day; pre-authorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or $50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$50 / retail supply or $110 / designated retail or mail service 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; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	20% coinsurance	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	In-network deductible applies first for in-network and out-of-network services; copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	In-network deductible applies first for in-network and out-of-network services
	Urgent care	$35 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable

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 a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$500 / admission	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	20% 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	No charge	20% coinsurance	
	Childbirth/delivery facility services	$500 / admission	20% 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	No charge	20% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first except for in-network outpatient services; limited to 100 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	$20 / visit	20% 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	No charge	20% 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, including supplies (20% coinsurance for out-of-network)
	Hospice services	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% 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 glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care (12 visits per calendar year)
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam per calendar year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-486-1136 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	$250
■ Delivery fee copay	$0
■ Facility fee copay	$500
■ Diagnostic tests copay	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$250
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$810**

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

■ The plan's overall deductible	$250
■ Specialist visit copay	$35
■ Primary care visit copay	$20
■ Diagnostic tests copay	$0

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

■ The plan's overall deductible	$250
■ Specialist visit copay	$35
■ Emergency room copay	$100
■ Ambulance services copay	$0

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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.

001652563

55-0647 (6/23)

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**.

001651238

55-1487 (6/23)

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/عربية:

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**).

001651831
55-1493 (6/23)

MASSACHUSETTS

SUMMARY OF BENEFITS

DENTAL BLUE® FREEDOM

(WITH ORTHODONTICS)

OPTION 1

LOWER PIONEER VALLEY EDUCATION

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

Download the app, or create an account at **bluecrossma.org.**

DENTAL BLUE FREEDOM WITH ORTHODONTICS

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	$25 Per Member/$75 Per Family Calendar-Year Deductible (in-network and out-of-network combined)	
Full Coverage*	50% Coverage*	50% Coverage*
$2,000 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)		

Diagnostic
- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- Bitewing X-rays twice per calendar year
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams twice per calendar year
- Emergency exams

Preventive
- Routine cleaning, scaling, and polishing of the teeth twice per calendar year
- Fluoride treatment twice per calendar year (members under age 19)
- Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per bicuspid or molar surface each 48 months.
- Space maintainers needed due to premature tooth loss (members under age 19)

Restorative
- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period)
- Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery
- Tooth extraction
- Root removal
- Biopsies

Periodontics (gum and bone)
- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)
- Root canal therapy (permanent teeth, once in a lifetime per tooth)
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- Other endodontic surgery to treat or remove the dental root

Prosthetic Maintenance
- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- Adding teeth to an existing complete or partial denture
- Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Services
- Occlusal adjustments once each 24 months
- Services to treat root sensitivity
- General anesthesia when administered in conjunction with covered surgical services
- Emergency dental care to treat acute pain or to prevent permanent harm to a member**

Prosthodontics (teeth replacement)
- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- Adding teeth to an existing bridge
- Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)

Major Restorative (members age 16 or older)
- Crowns, once each 60 months for each tooth
- Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Post and core or crown buildup, once each 60 months for each tooth

Implants (members age 16 or older)
- Single tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars

Orthodontic Benefit Group

Full coverage*
No deductible
- Complete orthodontic exam
- Comprehensive or limited active orthodontic treatment, including appliances

$1,000 Lifetime Benefit Maximum

* Benefits are reduced by 20 percent when services are received from an out-of-network dentist.
** Emergency care services are not subject to the calendar-year deductible. When you require emergency care by an out-of-network dentist, benefits are provided at the same level as an in-network dentist.

WELCOME TO DENTAL BLUE FREEDOM,

A DENTAL PLAN DESIGNED TO MANAGE THE COST OF DENTAL SERVICES.

Your Dentist
Dental Blue Freedom offers a large network of dentists, including dentists in Massachusetts and Rhode Island who participate with Blue Cross Blue Shield of Massachusetts. Dental Blue Freedom members also have access to participating dentists nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

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

Your Benefits
You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

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

Pre-Treatment Estimates
If your dentist expects that your dental treatment will involve covered services that will cost more than $250, Blue Cross Blue Shield recommends that your dentist send a copy of the "treatment plan" to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service. Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year or lifetime benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year or lifetime benefit maximum or eligibility status has changed.)

Multi-Stage Procedures
Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure. You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Network Dentists Are Paid – Preferred Dentists
You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

Payments are calculated based on the provisions of the Blue Cross Blue Shield preferred dentist's payment agreement and the dentist's allowed charge that is in effect at the time the covered dental service is provided. Preferred dentists agree to accept the allowed charge as payment in full. You pay your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year or lifetime benefit maximum.

How Network Dentists Are Paid – Participating Dentists
For dentists who participate with Blue Cross Blue Shield, but do not have a Blue Cross Blue Shield preferred provider contract, benefits are calculated based on the provisions of the participating dentist's payment agreement and the dentist's allowed charge. These dentists agree to accept the allowed charge as payment in full. You pay your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year or lifetime benefit maximum.

How Out-of-Network Dentists Are Paid – Non-Preferred or Non-Participating Dentists
Benefits for covered services by a non-preferred or non-participating dentist are provided based on the allowed charge or the dentist's actual charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year or lifetime benefit maximum.

Orthodontic Benefits
Your plan includes orthodontic coverage. The lifetime benefit maximum is not part of your calendar-year benefit maximum; it applies only to orthodontic services. You are responsible for your coinsurance (if applicable) and any charges beyond your lifetime benefit maximum. Benefits are available on your effective date. If your orthodontic treatment began before you were covered under Dental Blue Freedom, a monthly fee will be paid for your remaining orthodontic visits until either your treatment is completed or the lifetime benefit maximum is exhausted, whichever comes first.

When Coverage Begins
You are covered, without a waiting period, from the date you enroll in the plan.

Dependent and Student Benefits
This plan covers your unmarried dependent children until age 19, or full-time students until age 25. Student coverage ends when the student turns 25, or marries, or on November 1 following the date the student discontinues full-time classes or graduates, whichever comes first. A disabled child over age 19 may qualify for continued coverage under a family membership. Notify the plan sponsor before the child's 19th birthday.

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

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

If You Have to File a Claim
Network dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist as long as the claims are received within one year of the completed service.

If you receive care from an out-of-network dentist, you will typically need to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service.

After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

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

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

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

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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

April 2022

MASSACHUSETTS

DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

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

HOW MAXIMUM ROLLOVER WORKS

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

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

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

You can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures. This benefit applies to you automatically if:

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

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

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

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MASSACHUSETTS

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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**.

000489593

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**).

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Arabic/ةيبر:

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

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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'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

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55-1493 (6/21)

MASSACHUSETTS

SUMMARY OF BENEFITS

DENTAL BLUE® FREEDOM

(WITH ORTHODONTICS)

LOWER PIONEER VALLEY EDUCATION

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

Download the app, or create an account at **bluecrossma.org.**

DENTAL BLUE FREEDOM WITH ORTHODONTICS

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	$50 Per Member/$150 Per Family Calendar-Year Deductible (in-network and out-of-network combined)	
Full Coverage*	80% Coverage*	50% Coverage*
$2,000 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)		

Diagnostic
- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- Bitewing X-rays twice per calendar year
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams twice per calendar year
- Emergency exams

Preventive
- Routine cleaning, scaling, and polishing of the teeth twice per calendar year
- Fluoride treatment twice per calendar year (members under age 19)
- Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per bicuspid or molar surface each 48 months.
- Space maintainers needed due to premature tooth loss (members under age 19)

Restorative
- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period)
- Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery
- Tooth extraction
- Root removal
- Biopsies

Periodontics (gum and bone)
- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)
- Root canal therapy (permanent teeth, once in a lifetime per tooth)
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- Other endodontic surgery to treat or remove the dental root

Prosthetic Maintenance
- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- Adding teeth to an existing complete or partial denture
- Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Services
- Occlusal adjustments once each 24 months
- Services to treat root sensitivity
- General anesthesia when administered in conjunction with covered surgical services
- Emergency dental care to treat acute pain or to prevent permanent harm to a member**

Prosthodontics (teeth replacement)
- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- Adding teeth to an existing bridge
- Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)

Major Restorative (members age 16 or older)
- Crowns, once each 60 months for each tooth
- Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Post and core or crown buildup, once each 60 months for each tooth

Implants (members age 16 or older)
- Single tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars

Orthodontic Benefit Group

Full coverage*
No deductible
- Complete orthodontic exam
- Comprehensive or limited active orthodontic treatment, including appliances

$1,000 Lifetime Benefit Maximum

* Benefits are reduced by 20 percent when services are received from an out-of-network dentist.
** Emergency care services are not subject to the calendar-year deductible. When you require emergency care by an out-of-network dentist, benefits are provided at the same level as an in-network dentist.

WELCOME TO DENTAL BLUE FREEDOM,

A DENTAL PLAN DESIGNED TO MANAGE THE COST OF DENTAL SERVICES.

Your Dentist
Dental Blue Freedom offers a large network of dentists, including dentists in Massachusetts and Rhode Island who participate with Blue Cross Blue Shield of Massachusetts. Dental Blue Freedom members also have access to participating dentists nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

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

Your Benefits
You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

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

Pre-Treatment Estimates
If your dentist expects that your dental treatment will involve covered services that will cost more than $250, Blue Cross Blue Shield recommends that your dentist send a copy of the "treatment plan" to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service. Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year or lifetime benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year or lifetime benefit maximum or eligibility status has changed.)

Multi-Stage Procedures
Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure. You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Network Dentists Are Paid – Preferred Dentists
You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

Payments are calculated based on the provisions of the Blue Cross Blue Shield preferred dentist's payment agreement and the dentist's allowed charge that is in effect at the time the covered dental service is provided. Preferred dentists agree to accept the allowed charge as payment in full. You pay your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year or lifetime benefit maximum.

How Network Dentists Are Paid – Participating Dentists
For dentists who participate with Blue Cross Blue Shield, but do not have a Blue Cross Blue Shield preferred provider contract, benefits are calculated based on the provisions of the participating dentist's payment agreement and the dentist's allowed charge. These dentists agree to accept the allowed charge as payment in full. You pay your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year or lifetime benefit maximum.

How Out-of-Network Dentists Are Paid – Non-Preferred or Non-Participating Dentists
Benefits for covered services by a non-preferred or non-participating dentist are provided based on the allowed charge or the dentist's actual charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year or lifetime benefit maximum.

Orthodontic Benefits
Your plan includes orthodontic coverage. The lifetime benefit maximum is not part of your calendar-year benefit maximum; it applies only to orthodontic services. You are responsible for your coinsurance (if applicable) and any charges beyond your lifetime benefit maximum. Benefits are available on your effective date. If your orthodontic treatment began before you were covered under Dental Blue Freedom, a monthly fee will be paid for your remaining orthodontic visits until either your treatment is completed or the lifetime benefit maximum is exhausted, whichever comes first.

When Coverage Begins
You are covered, without a waiting period, from the date you enroll in the plan.

Dependent and Student Benefits
This plan covers your unmarried dependent children until age 19, or full-time students until age 25. Student coverage ends when the student turns 25, or marries, or on November 1 following the date the student discontinues full-time classes or graduates, whichever comes first. A disabled child over age 19 may qualify for continued coverage under a family membership. Notify the plan sponsor before the child's 19th birthday.

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

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

If You Have to File a Claim
Network dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist as long as the claims are received within one year of the completed service.

If you receive care from an out-of-network dentist, you will typically need to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service.

After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

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

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

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

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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

April 2022

MASSACHUSETTS

DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

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

HOW MAXIMUM ROLLOVER WORKS

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

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

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

You can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures. This benefit applies to you automatically if:

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

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

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

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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**）。

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Arabic/ةيبر:

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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'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

000489691

55-1493 (6/21)

MASSACHUSETTS

BLUE 20/20 EXAM-PLUS VISION PLAN: ACCESS NETWORK

$130 Frame, $25 Lens, 12/12/24 Frequency

Vision care service	In-network member cost	Out-of-network reimbursement[1]
Comprehensive eye exam	$10 copay	Up to $50
Contact lens fit and follow-up[2]		
• Standard	Up to $55	n/a
• Premium	10% off retail price	n/a
Retinal imaging	Up to $39	n/a
Enhanced Diabetes Eye Care Benefit[3] For members diagnosed with type 1 or type 2 diabetes	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	n/a
Coverage for enrolled kids under 19		
• Exam	$0 copay, up to two per benefit frequency	Up to $50
• Standard plastic lenses	Up to two per benefit frequency[4]	Up to $42–$196
• Standard polycarbonate lens	Paid in full	Up to $26
• Rx Blue-light lens treatment	Paid in full	Up to $14
Frames	$130 allowance, then additional 20% off the balance	Up to $74
Standard plastic lenses		
• Single vision	$25 copay	Up to $42
• Bifocal	$25 copay	Up to $78
• Trifocal, lenticular	$25 copay	Up to $130
• Standard progressive lens	$90 copay	Up to $140
• Premium progressive lens	$90 copay, then 80% of charge less $120 allowance	Up to $196
Lens options[2]		
• UV treatment	$15	n/a
• Tint (solid and gradient)	$15	n/a
• Standard plastic scratch coating	$15	n/a
• Standard polycarbonate	$40	n/a
• Standard anti-reflective coating	$45	n/a
• Photochromic/Transitions®✓ plastic	20% off retail price	n/a
• Polarized	20% off retail price	n/a
• Other add-ons	20% off retail price	n/a
Contact lenses[5]		
• Conventional	$130 allowance, then additional 15% off the balance	Up to $104
• Disposable	$130 allowance	Up to $104
• Medically necessary	Paid in full	Up to $210
Frequency		
• Exam	Once every 12 months	
• Lenses for frames or one order of contact lenses	Once every 12 months	
• Frames	Once every 24 months	

ADDITIONAL IN-NETWORK SAVINGS AND DISCOUNTS

40%

off a complete second pair of glasses

20%

off non-prescription sunglasses

15%

off retail price or 5% off promotional price for laser vision correction through U.S. Laser Network

For costs and further details about the coverage, including exclusions, refer to your benefit details.
1. Your actual expenses for covered services may exceed the stated out-of-network amount. 2. Indicates a service that is a discounted arrangement as part of your vision plan.
3. Consult your eye care provider. 4. Minimum prescription change required. 5. Discount applies to materials only and not to fittings for contact lenses.

BENEFITS YOU CAN SEE — FROM A COMPANY YOU TRUST

Access to one of the nation's largest vision networks

Thousands of independent providers

Award-winning customer service

Favorite national retailers

LENSCRAFTERS

PEARLE VISION

TARGET OPTICAL

and many regional retailers.

Online shopping options

- Glasses.com
- Contactsdirect.com
- Ray-Ban.com
- Targetoptical.com
- Lenscrafters.com
- Oakley.com

SPECIAL OFFERS FOR ADDITIONAL SAVINGS

Find them at **blue2020ma.com**.

KIDS UNDER 19 DISCOUNT

35% OFF

non-prescription blue-light glasses

Save on hearing exams and hearing aids

Offered by Amplifon Hearing, an independent company. To learn more about the savings available, visit **amplifonusa.com/blue2020**. To get started, call **1-866-921-5367**.

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

Questions?

Call Member Service at **1-855-875-6948**. To locate an in-network provider and find discount information, visit **www.blue2020ma.com**.

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.
ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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MASSACHUSETTS

BLUE 20/20

LITTLE EYES, BIG BENEFITS

Enhanced vision coverage for kids under 19

Eye care is so important – especially for kids. Correcting vision problems at an early age can have a lasting, positive impact, such as improving the ability to learn. We want to make sure kids get the right care at the right time by offering enhanced vision coverage, at no additional cost, for kids under 19 who are enrolled in select Blue 20/20 plans.[1]

Enhanced vision coverage for kids under 19	Coverage
The following coverage is in addition to the comprehensive coverage already provided by our Blue 20/20 plans.	
Two fully covered eye exams at $0 copay per benefit frequency	✓
One pair of replacement lenses (subject to a prescription change) per benefit frequency	✓
Fully covered blue-light prescription lenses treatment	✓
Fully covered standard polycarbonate lenses	✓

SAVINGS AND DISCOUNTS

40% off
replacement glasses from in-network locations

35% off
non-prescription, blue-light glasses[2]
New for kids under 19

20% off
sports-related eyewear and non-prescription sunglasses

WHAT YOU NEED TO KNOW

Enhanced vision coverage will be added automatically to select Blue 20/20 plans

Enhanced vision coverage is included at no additional cost

Enhanced vision coverage applies to in-network vision providers

Learn more

To see plan details and discount information, visit **www.blue2020ma.com**.

1. Applicable plans include Exam Plus vision plans. Does not apply to Materials Only and Exam Only vision plans. Check your benefit details to confirm your coverage. Enhanced coverage will be applied automatically to eligible plans on July 1, 2024.
2. Starting July 1, 2024.

We partner with EyeMed®℠ Vision Care, an independent vision benefits company, to offer our comprehensive vision plans.

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

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
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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**).

002972247 55-002382519 (6/24)

SVRHTCanaRx

http://svrhtcanarx.com/

Members now have access directly from **CanaRx** to certain brand name medications at NO COST to the member,
and they will be delivered by mail right to your doorstep!

Your medication may be on the list of available medications – please visit the SVRHTCanaRx.com website or call CanaRx to find out!

SVRHTCanaRx is a voluntary international prescription drug program that is available to eligible Employees, Non-Medicare eligible Retirees, and their Dependents enrolled in the HMO or PPO plans with the Scantic Valley Regional Health Trust.
The HNE MedPlus plan is also eligible for this program.

***SVRHTCanaRx** is a voluntary program and does not replace your current prescription benefit plan.*

Questions, Contact Our Customer Service Representatives Toll free at 1-866-893-(MEDS) 6337.

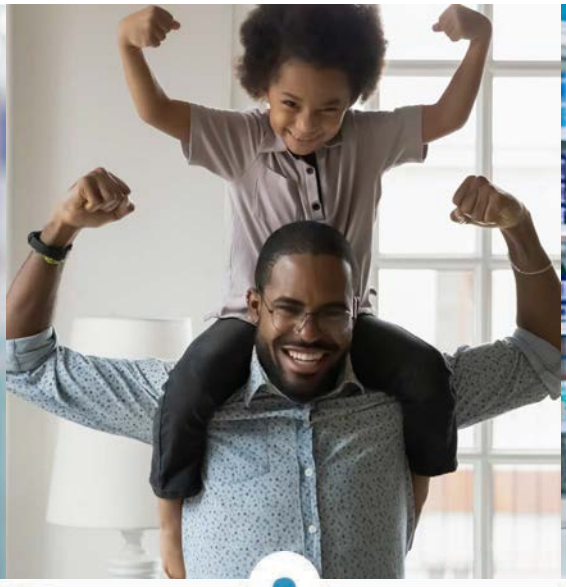
SVRHTCanaRx

**Similar to a number of states in the US, some Canarx pharmacies require a copy of photo ID be provided prior to dispensing the medications. In order to prevent order delays, we encourage patients to include a clear copy of their photo identification with their enrollment form. If not included, a Canarx representative will contact you when required by the pharmacy dispensing your medications.*

3 REASONS TO JOIN

The Diabetes Care Rewards Program
at GoodHealthGateway.com

SCAN ME TO JOIN



1. YOUR DOCTORS

See your doctors to complete routine diabetes labs and exams recommended by the American Diabetes Association.

2. YOUR HEALTH

Manage your diabetes effectively with the help of our timely reminders to see your doctors so you live healthy and feel well.

3. YOUR REWARDS

Earn $0 copays on your diabetes medications and supplies when you join at no cost to you and complete your labs and exams.

The **Good Health Gateway**® Diabetes Care Rewards Program is a free benefit offered by Scantic Valley Regional Health Trust to their health plan members. **Participation is voluntary and confidential.**

Join Today

800.643.8028 | Hablamos español.
GoodHealthGateway.com

Scantic Valley
Regional Health Trust

Good Health GATEWAY®
Diabetes Care Rewards Program

Available to the following member employers of the Scantic Valley Regional Health Trust:

Hampden Wilbraham Regional School District
Lower Pioneer Valley Educational Collaborative

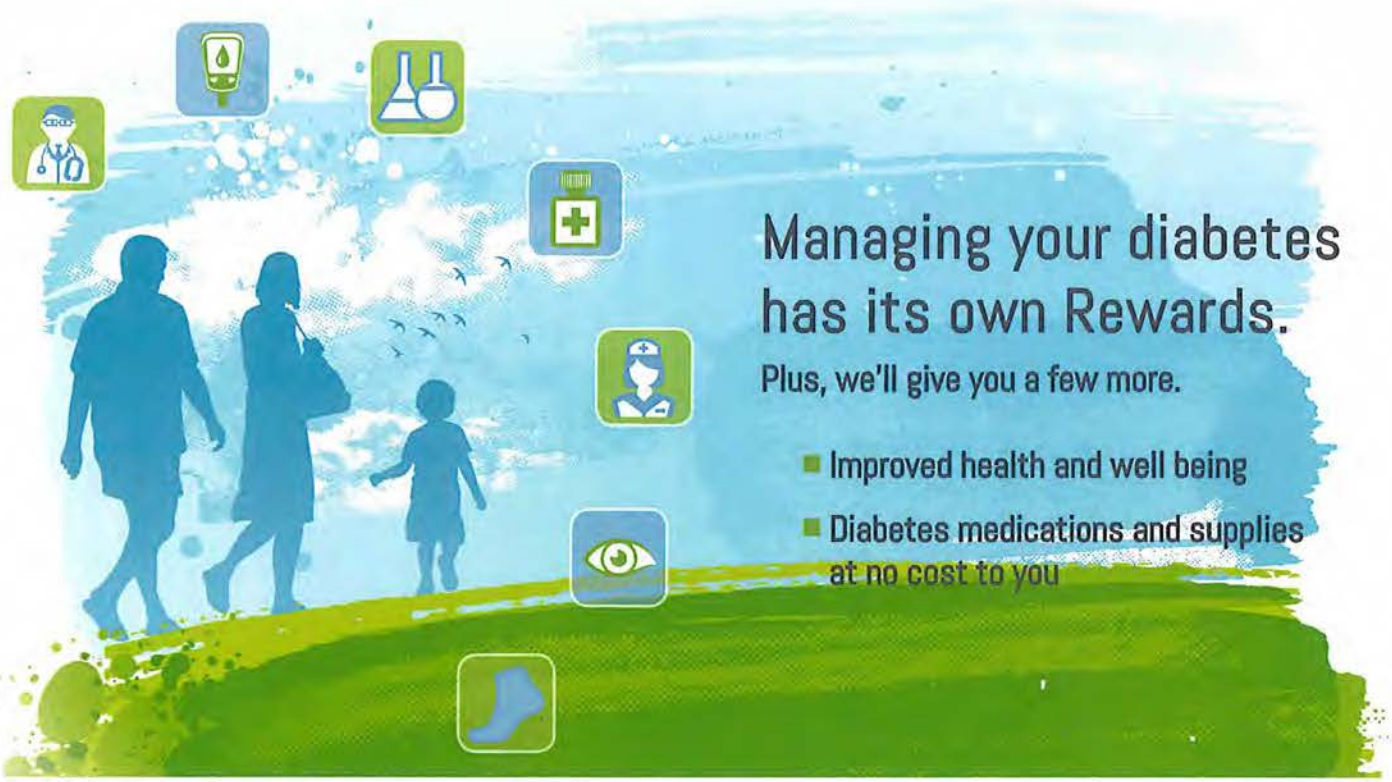
Town of:
- East Longmeadow
- Hampden
- Longmeadow
- Wilbraham

For employees and their covered dependents of the above employers insured through one of the following Scantic Valley Regional Health Trust sponsored health plans:

Blue Cross Blue Shield of Massachusetts
Network Blue HMO, Network Blue HMO Deductible, Blue Care Elect Preferred PPO, Blue Care Elect Preferred PPO Deductible

Health New England
HNE HMO, HNE HMO Deductible

Tufts Health Plan
Tufts Choice Co-pay EPO, Tufts Advantage EPO Deductible



Join the **Good Health Gateway® Diabetes Care Rewards Program**, and you can be on your way to better health and receiving diabetes medications, test strips, and other diabetes supplies for $0 copays using your **Good Health Gateway® Rx Rewards Card**.

- Register at **GoodHealthGateway.com**.
- Complete a brief telephone conversation with our **Good Health Gateway** Diabetes Educator to get your written **Diabetes Health Action Plan®** Care Guide to review and share with your doctor. Call 800.643.8028 to schedule your conversation.
- Complete the basic requirements for managing your diabetes such as having important diabetes screenings and exams.
- Send us your Provider Confirmation Form(s) completed by your healthcare provider(s), and we will send you a **Good Health Gateway Rx Rewards Card** to get $0 copays on your covered diabetes medications and supplies. Forms can be uploaded to our website, faxed, or mailed.

Plus, registered members age 18 and over can get a free Accu-Chek® Guide meter and ongoing test strips for free. Call for details.

Your participation is voluntary and confidential. HIPAA privacy and security standards are used to ensure the protection of your healthcare information.

To learn more, call our HelpLine or register online.

Join Today!
800.643.8028
GoodHealthGateway.com

Good Health GATEWAY®
Diabetes Care Rewards Program

0719

Diabetes Care: The Importance of A1C Tests

A1C, also called hemoglobin A1C or HbA1c, is one of the commonly used blood tests to diagnose pre-diabetes and diabetes. An A1C test is also used to monitor how well your diabetes treatment plan is working over time, and is an important tool in determining if changes to your treatment plan should be discussed with your doctor and diabetes care team.

Your A1C test measures your average blood sugar levels over the past 3 months. The higher the levels, the greater your risk of developing type 2 diabetes or diabetes complications. Your doctor will tell you how often you need an A1C test, but usually you will have the test at least twice a year.

When it comes to the numbers, there's no one-size-fits-all.

The goal for most adults with diabetes is an A1C less than 7%. Your personal A1C goal may be different from someone else's since factors such as age and other medical conditions are taken into consideration. It's important that you work with your diabetes care team to set your own personal A1C goal.

A1C Ranges	Non-diabetes	Pre-diabetes	Diabetes
	Below 5.7%	Between 5.7% and 6.4%	6.5% or higher

If you have pre-diabetes or any form of diabetes and are on a Town or School District health plan, enroll in the Good Health Gateway® Diabetes Care Rewards Program at no cost to you.

You'll get expert guidance from our Diabetes Educators (Nurses, Pharmacists, Nutritionists) in improving or maintaining your A1C and health goals. **The Program has helped members lower their A1, and can help you too. Plus, you'll get $0 copays on your diabetes medications and supplies** when you see your diabetes care team and complete the program's diabetes care activities recommended by the American Diabetes Association.

Join Today

800.643.8028 | Hablamos español.
GoodHealthGateway.com

Good Health GATEWAY®
Diabetes Care Rewards Program

Massachusetts Deferred Compensation SMART Plan

PARTICIPATE

457 PLAN FOR LOWER PIONEER VALLEY EDUCATIONAL COLLABORATIVE

PLAN OVERVIEW

SAVE FOR THE FUTURE

Congratulations!

You are eligible to join the Massachusetts Deferred Compensation SMART Plan. This supplemental retirement savings program offers a convenient way to **S**ave **M**oney **A**nd **R**etire **T**omorrow.

This booklet includes specific information about the SMART Plan, as well as general information about the benefits of saving through the SMART Plan.

Where will your retirement income come from?

Pension benefits and Social Security may help cover some of your expenses in retirement.

Participating in the SMART Plan allows you to defer a portion of your salary now so you will have access to it in the future.

Windfall Elimination Provision

The Windfall Elimination Provision (WEP) reduces the Social Security benefit for individuals who have held a job that provided a pension benefit but did not require Social Security income tax deductions from their earnings.

The reduction in the Social Security benefit is based on the number of years the individual held a job during which they did not have to pay into Social Security. The WEP will not eliminate an individual's entire Social Security benefit but could reduce it by up to half the amount of the individual's pension.

You can learn more details by searching for *Windfall Elimination Provision* at **www.ssa.gov**.

Government Pension Offset

The Government Pension Offset is similar to the Windfall Elimination Provision. The difference is that this program reduces spousal Social Security benefits. Again, if there was a period during an individual's career when they received a pension benefit and did not have to contribute to Social Security, the survivor benefits that the individual's spouse receives will be reduced.

The spousal Social Security survivor benefits will be reduced by two-thirds the amount the individual's pension benefit provides.

You can learn more details by searching for *Government Pension Offset* at **www.ssa.gov**.

HOW DOES THE SMART PLAN WORK?

The SMART Plan is a retirement savings program authorized under section 457 of the Internal Revenue Code, commonly called a 457 deferred compensation program, that allows eligible employees to save and invest before-tax and after-tax dollars through salary deferrals (contributions).

1. You decide, within IRS limits, how much of your income you want to defer.
2. You decide whether to contribute on a before- or after-tax (Roth) basis.
3. Your contributions will be invested, per your instructions, in the investment options offered under the SMART Plan. You can also choose different fund allocations within your traditional and Roth accounts from your SMART Plan fund lineup.
4. Saving through the SMART Plan on a pretax basis may reduce your current federal income tax responsibility.

Remember: Distributions from a before-tax SMART Plan account will be taxed as ordinary income in the year the money is distributed. Distributions of any earnings from an after-tax SMART Plan account will be taxed as ordinary income if you have not contributed to a Roth account for more than five tax years. Account values fluctuate with market conditions, and when surrendered, the principal value may be worth more or less than the original amount invested.

Fees

An annual recordkeeping and communications fee will be charged at the following rates:

- $10 annually per account (on accounts over $1,000)
- 0.07% on total assets in your account

These fees are capped at $350 annually and assessed monthly.

An annual administration fee of 0.0075% of your account balance will be charged on a monthly basis.

In addition to the administrative fee, each of your investment options has an investment management fee. Fees vary by option and are disclosed in the fund performance document and fund fact sheets. You can obtain copies by visiting the SMART Plan website at **www.mass-smart.com** or by calling the SMART Plan Service Center at **877-457-1900**.

The before-tax advantage

Tax deferral is beneficial in three ways:

1. It lowers your current taxable income because you postpone paying taxes on contributions made to the SMART Plan.
2. It allows more of your money to work for you. This includes money that you ordinarily would have paid in federal income taxes. Tax-deferred compounding occurs when any earnings on your account are reinvested and given the chance to earn more money.
3. The contributions and any earnings that accumulate over the years are not taxed until you receive them. That's usually during retirement, when you may be in a lower tax bracket.

The Roth advantage

The Roth option reduces your take-home pay dollar for dollar and offers the following benefits:

1. It essentially locks in today's tax rates on all contributions.
2. For those who expect to be in a higher tax bracket when they retire, the Roth option allows you to pay taxes on your contributions when they are contributed (presumably at a lower tax rate than you would expect to pay at retirement).

To illustrate how before-tax contributions affect your paycheck, let's assume you earn $30,000 in taxable income annually and you want to defer 8% (approximately $93) from each paycheck to the SMART Plan. You're paid every other week — 26 times a year.

	Paycheck before joining the SMART Plan	Paycheck after joining the SMART Plan
Income after adjustments	$1,154	$1,154
SMART Plan contribution (8%)	$0	$93
Net taxable income	$1,154	$1,061
Federal income tax (15%)	$173	$159
Take-home pay	$981	$902

FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration assumes a participant earning $1,154 per paycheck in regular pay who contributes 8% per paycheck in the SMART Plan. It also assumes 15% federal and state income tax withholding but does not account for local income tax withholding or Medicare, Social Security or other taxes.

TRADITIONAL 457 VS. ROTH 457 CONTRIBUTIONS

You may be asking yourself, "How do I know which option is the best choice for me?" It's a good question.

You might want to consult with a financial planner, attorney and/or tax advisor to help evaluate your particular situation. Take time to truly analyze your current financial circumstances, spending habits and long-term retirement aspirations.

The SMART Plan gives you the flexibility to designate all or a portion of your 457 elective deferrals as traditional before-tax contributions or Roth after-tax contributions.

If you are not yet participating in the SMART Plan, you can enroll on the website at **www.mass-smart.com** by completing the Participant Enrollment form found on the website or by calling the SMART Plan Service Center at **877-457-1900**.

If you're a current SMART Plan participant, you can change your contributions by logging in to your account at **www.mass-smart.com**. Click on *My Accounts*, then *My Contributions*. You can also contact the SMART Plan Service Center at **877-457-1900**.

Here are some key differences between traditional 457 and Roth 457 accounts:

Traditional 457

- Contributions are made with before-tax dollars.
- Contributions are taxed when distributed.
- Any potential earnings on your contributions are taxed when distributed.
- You have more take-home pay in your paycheck than if you made the same contribution to a taxable account.

Roth 457

- Contributions are made with after-tax dollars.
- All qualified distributions are entirely free of income taxes and penalties.
- Any Roth money, including contributions and potential earnings, will grow tax free in your account.
- Your take-home pay in your paycheck is reduced dollar for dollar.

Regardless of which contribution option you select, you should consider contributing as much as you can and participate no matter what. You're saving for your retirement, your future — and that's a good thing.

THE COST OF WAITING

Waiting to save and invest in the SMART Plan could cost you more than you think. The sooner you start, the more time you are giving your investments to potentially grow. So it's important to get started now — no matter how old you are.

Here are two hypothetical employees who both began working at age 25.

Anne

Benefits Coordinator

- Began contributing to the SMART Plan at age 25
- Contributes $100/month for the next 15 years
- At age 40 has to stop contributions to the SMART Plan in order to fulfill other obligations

Total contributions: $18,000

John

Systems Analyst

- Quickly spends his earnings
- Doesn't really save any money
- Waits until after he gets married at age 35 to begin contributing $100/month to the SMART Plan for the next 30 years

Total contributions: $36,000

Here is a hypothetical illustration assuming a 6% annual rate of return.

Who could have more money at age 65?

Age	Anne's monthly contribution	Anne's end-of-year balance	John's monthly contribution	John's end-of-year balance
25	$100	$1,234	$0	$0
30	$100	$6,977	$0	$0
35	$100	$16,388	$100	$1,234
40	$0	$29,082	$100	$6,977
45	$0	$39,227	$100	$16,388
50	$0	$52,912	$100	$29,082
55	$0	$71,370	$100	$46,204
60	$0	$96,267	$100	$69,299
65	$0	$129,850	$100	$100,452

If Anne had the opportunity to keep contributing to the SMART Plan until age 65, her end-of-year balance could be **$199,149**.

FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration does not represent the performance of any investment options. It assumes a $30,000 annual salary, 6% annual rate of return and reinvestment of earnings, with no withdrawals. Rates of return may vary. The illustration does not reflect any charges, expenses or fees that may be associated with the SMART Plan. The tax-deferred accumulations shown above would be reduced if these fees were deducted.

Compounding growth

When you invest money in the SMART Plan, your money can potentially grow from investment gains or dividends.

Any money gained through growth and earnings is then put back into your account, or reinvested. So the total amount includes the new gains, which are added to the original amount you invested. This process of building on any gains continues year after year. It's known as compounding. Anne's longer timeline means she is potentially better able to take advantage of compounding growth.

BENEFITS TO THE SMART PLAN

SMARTPath Retirement Funds

If you do not make an election for investing your retirement account when you enroll in the SMART Plan, your contributions will be invested in the SMART Plan's default investment option, the SMARTPath Retirement Funds. Please see the chart below to determine which SMARTPath Retirement Fund you will be defaulted into. You can find detailed information regarding the default option in which you are enrolled, as well as performance information, prospectuses and the disclosure documents, by logging into your new account at **www.mass-smart.com**.

Generally, the further the fund is from its target retirement year, the greater your SMARTPath Retirement Fund's allocation to stock and diversifying investments.[1] This emphasizes the growth potential to potentially build savings over the long term.

As the fund moves closer to its target retirement year, the fund's asset allocation automatically adjusts to a mix expected to experience lower volatility under a broad range of market conditions. By the time the fund reaches its date, the SMARTPath Retirement Fund will be invested in a mix of stocks, bonds and diversifiers focused on preserving savings and producing income.

Date of Birth	SMARTPath Retirement Fund[2,3]	Expected Retirement Date Range
1942 or before	SMARTPath Retirement Allocation Fund	2007 or before
1943-1947	SMARTPath 2010 Retirement Fund	2008-2012
1948-1952	SMARTPath 2015 Retirement Fund	2013-2017
1953-1957	SMARTPath 2020 Retirement Fund	2018-2022
1958-1962	SMARTPath 2025 Retirement Fund	2023-2027
1963-1967	SMARTPath 2030 Retirement Fund	2028-2032
1968-1972	SMARTPath 2035 Retirement Fund	2033-2037
1973-1977	SMARTPath 2040 Retirement Fund	2038-2042
1978-1982	SMARTPath 2045 Retirement Fund	2043-2047
1983-1987	SMARTPath 2050 Retirement Fund	2048-2052
1988-1992	SMARTPath 2055 Retirement Fund	2053-2057
1993-1997	SMARTPath 2060 Retirement Fund	2058-2062
1998 or after	SMARTPath 2065 Retirement Fund	2063 or after

You can choose how to invest your retirement account — both your current account balance and your future contributions — at any time by calling the SMART Plan Service Center at **877-457-1900** or visiting **www.mass-smart.com**.

The date in a target date fund's name represents an approximate date when an investor is expected to retire (which is assumed to be at age 65) and/or begins withdrawing money. The principal value of the funds is not guaranteed at any time, including at the target date. For more information, please refer to the fund prospectus and/or disclosure document.

Consider all your options and their features and fees before moving money between accounts.

Carefully consider the investment option's objectives, risks, fees and expenses. Contact Empower for a prospectus, summary prospectus for SEC-registered products or disclosure document for unregistered products, if available, containing this information. Read each carefully before investing.

1 Diversification and asset allocation do not ensure a profit or protect against loss.

2 Asset allocation and balanced investment options and models are subject to the risks of their underlying investments.

3 As of December 1, 2014, the default investment option is the SMARTPath Retirement Funds.

MORE BENEFITS TO THE SMART PLAN

Contributing made easier

Your contributions to the SMART Plan are conveniently deducted from your paycheck.

Multiple investment options

Choose from a variety of diversified, professionally managed investment options with competitive fees.

Flexibility

Change both the amount you are contributing (within IRS limits) and the way you are investing your contributions.

Portability

The SMART Plan is portable, meaning benefits accumulated from a previous employer's plan and/or a traditional IRA may be rolled into the SMART Plan. Conversely, if you change jobs, you can roll over your SMART Plan benefits into another eligible retirement plan or tax-qualified plan, such as an IRA. You may also leave your benefits in the SMART Plan, where they can continue to accumulate potential earnings tax deferred.

Keep in mind

Amounts rolled into the SMART Plan from other non-457(b) plans will remain subject to the IRS 10% premature distribution tax penalty for distributions taken prior to age 59½, unless an exception applies.

If you roll over your SMART Plan benefits into a plan type other than a 457(b) deferred compensation plan, those benefits will also be subject to the IRS 10% premature distribution penalty tax (unless an exception applies) if any distributions are taken from that new plan prior to age 59½.

Professional oversight

An independent investment consultant advises the treasurer and their staff in the development and implementation of the SMART Plan's investment policy and structure. It also assists in the selection and evaluation of the Plan administrator and investment managers.

2024 contribution limits

Annual limit: The minimum contribution amount per pay period to participate in the SMART Plan is 1% of your gross income or $10, whichever is less. You can contribute a maximum of 100% of compensation that you can include, not to exceed the annual IRS limit of $23,000 in 2024.

Age 50+ catch-up: If you are age 50 or older during the 2024 calendar year, you may contribute an additional $7,500 for a maximum contribution of $30,500 in 2024.

Three-year catch-up: During the three consecutive years prior to, but not including, the year you attain normal retirement age and if you have undercontributed to the SMART Plan or another employer-sponsored retirement plan in the past, you may be able to contribute an additional $23,000 in 2024. This amounts to a maximum contribution of $46,000 for 2024. If you elect to use the three-year catch-up provision, you are not required to make the maximum allowable contribution.

The three-year catch-up and age 50+ catch-up provisions cannot be used in the same calendar year. You should evaluate which catch-up provision is most favorable to you.

	Annual limit	Age 50+ catch-up for participants age 50 or older	Three-year catch-up prior to normal retirement
2024	$23,000	$30,500	$46,000
2025 and later	Expected to be adjusted for inflation in $500 increments		

Contribute as much as you can

Contribute as much as you can, based on your individual circumstances, and consider increasing your contributions with each pay raise. Even a small increase can make a big difference over time.

The following chart illustrates the potential long-term effect of increasing your contributions from 4% to 8% to 12% per pay period (26 pay periods).

Accumulation years	Contribution of 4% per pay period	Contribution of 8% per pay period	Contribution of 12% per pay period
5	$6,988	$13,976	$20,964
10	$16,417	$32,834	$49,252
15	$46,311	$92,621	$138,932
30	$100,742	$201,485	$302,227

FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration does not reflect a particular investment and is not a guarantee of future results. It assumes a 6% annual rate of return, reinvestment of earnings and no withdrawals. Rates of return may vary. The illustration does not reflect fees, which could change the outcomes provided.

Access to your money

Distributions are allowed under the following circumstances:

- Attainment of age 59½;
- Separation from service;
- Death (upon which your designated beneficiaries have access to benefits);
- Unforeseeable emergency (in accordance with IRS regulations); or
- In-service distributions of $5,000 (available in limited circumstances under the conditions of the SMART Plan). **For more details, please contact your local SMART Plan Retirement Plan Advisor.**

SERVICE YOU CAN COUNT ON

SMART Plan participants can access account information 24 hours a day, seven days a week via the website or by phone. The SMART Plan's approach to service is based on convenience — service is a call, click or visit away.

Call

SMART Plan Service Center
877-457-1900

- Speak to a customer service representative Monday through Friday, 8 a.m. to 10 p.m. Eastern time and Saturday 9 a.m. to 5:30 p.m. Eastern time.
- Access your automated account information 24 hours a day, seven days a week.

A customer service representative can assist you with your first-time access.

Local SMART Plan Retirement Plan Advisors: 877-457-1900, say "Representative"

Local SMART Plan Retirement Plan Advisors can assist you with your account as well as discuss your retirement objectives. They can provide you with information on all aspects of the SMART Plan, including:

- Enrollment
- Contribution limits
- Investment options
- Catch-up provisions
- Empower Advisory Services suite of services offered by Empower Advisory Group, LLC, a registered investment adviser[4]
- Distribution options

Web

www.mass-smart.com

In the Participant Login section, log in to:

- Make account inquiries.
- Conduct investment option transfers/allocation changes[5] (subject to Excessive Trading Policy).
- Obtain fund unit values and descriptions.
- Review fund performance (past performance does not guarantee future results).
- Activate automatic account rebalancing.
- Sign up for Advisory Services.

Registration for first-time users and login are required for online account access.

Mobile app

Download the Empower app[6] to:

- Check your account balance and history.
- View your estimated retirement income.
- See your paycheck contribution amount.
- Look at your current rate of return.
- Review the investment options in your portfolio.
- Make changes to your account.

Visit

In-person meetings may be available by appointment only. Please check with your local office in advance by emailing **SMART@empower.com** or by calling **877-457-1900**. Virtual meetings remain available and can be scheduled using the online appointment tool accessible from **www.mass-smart.com** > *Plan resources* > *Find your representative*. Written correspondence should only be directed to the Regional Service Center.

Regional Service Center

255 Bear Hill Road
Waltham, MA 02451

Other locations

Boston
One Winter Street, 8th Floor
Boston, MA 02108

Springfield
One Financial Plaza
1350 Main Street, Suite 1213
Springfield, MA 01103

Worcester
370 Main Street, Suite 610
Worcester, MA 01608

4 Online Advice and My Total Retirement are part of the Empower Advisory Services suite of services offered by Empower Advisory Group, LLC, a registered investment adviser.

5 Transaction requests received in good order after the close of the New York Stock Exchange will be processed the next business day.

6 Available in the App Store® from Apple® and on Google Play™.

SUPPORT YOU CAN RELY ON

Meeting your retirement objectives is a lot easier when you have the tools and support to help you. As a participant in the SMART Plan, you have access to *free* online planning tools and calculators at **www.mass-smart.com**.

- **Retirement planner**
  See your current savings, projected retirement income and expected Social Security benefits.
- **Savings planner**
  Review your savings to date and progress toward your individual goals.
- **Budgeting**
  View all transactions across accounts.
- **Investments**
  View your holdings, balance and performance.

Financial seminars

These free seminars are designed to help you meet your financial and retirement objectives. For more information, call your local SMART Plan Retirement Plan Advisor.

To find your nearest representative, visit **www.mass-smart.com** > *Plan Resources* > *Find your representative*.

SMART Plan update

This quarterly newsletter keeps you in the know with information about the SMART Plan, as well as interesting and educational articles about general finance topics.

Empower Advisory Services

The Empower Advisory Services suite of services offered by Empower Advisory Group, LLC, a registered investment adviser, offers personalized retirement strategies to help you meet your retirement income goals:

- My Total Retirement™ is based on your personal financial picture, professionally implemented and managed to address your savings, investing and retirement income needs. It also includes customized spending assistance to help you make the most of your savings.
- Online Advice offers fund-specific recommendations to help you validate or adjust your already developed strategy.

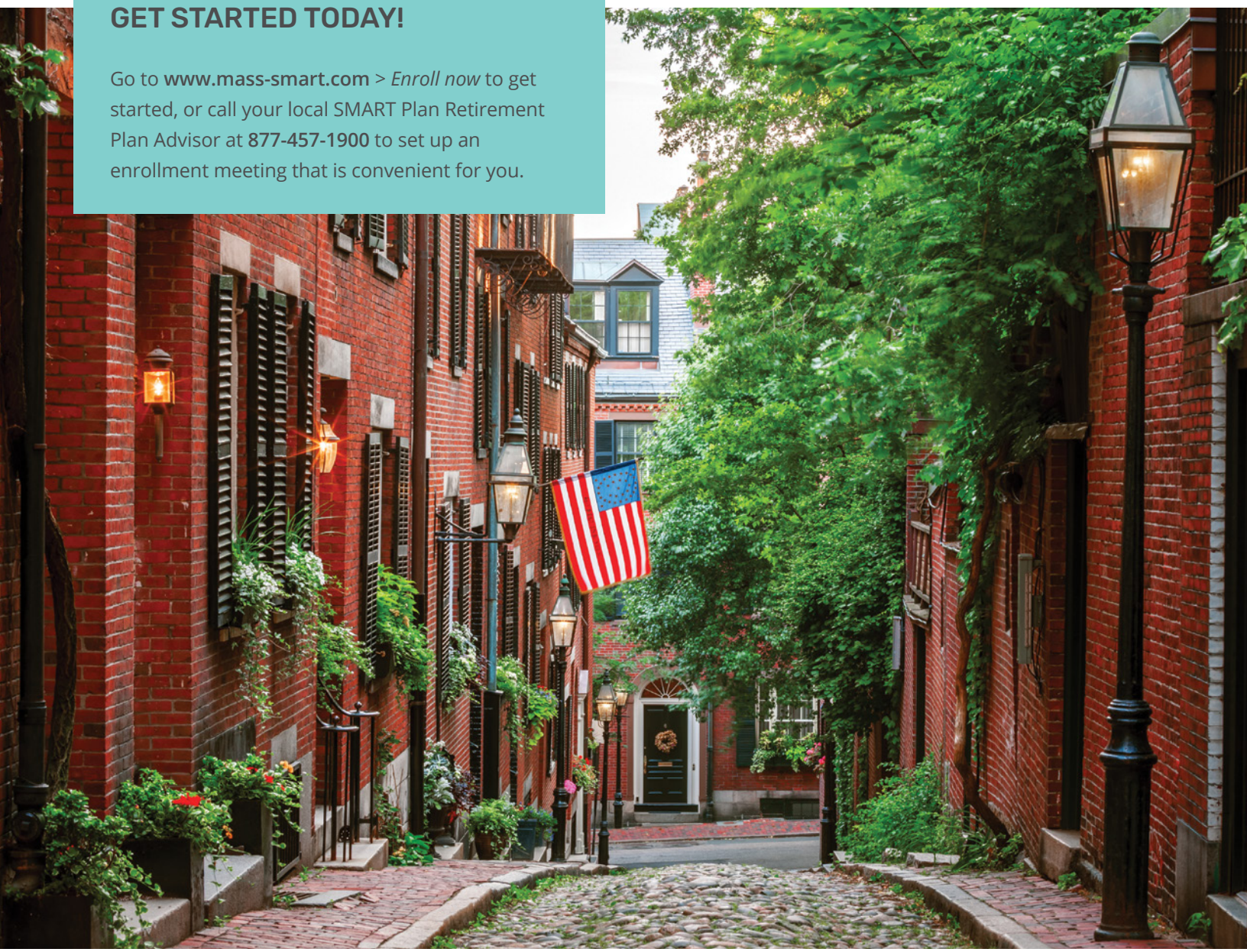
For complete details, refer to the *Two Paths to Investing for Retirement* brochure, found at **www.mass-smart.com** > *Plan Resources* > *Resources and Links*.

There is no guarantee provided by any party that participation in any of the advisory services will result in a profit.

To learn more about Advisory Services, go to **www.mass-smart.com** > *Investing* > *Investment Overview* or call the SMART Plan Service Center at **877-457-1900** to speak to a local SMART Plan Retirement Plan Advisor. Regardless of which option you choose, you get a personalized approach based on your finances, your risk tolerance and your investment objectives.

GET STARTED TODAY!

Go to **www.mass-smart.com** > *Enroll now* to get started, or call your local SMART Plan Retirement Plan Advisor at **877-457-1900** to set up an enrollment meeting that is convenient for you.



Investing involves risk, including possible loss of principal.

Securities, when presented, are offered and/or distributed by Empower Financial Services, Inc., Member FINRA/SIPC. EFSI is an affiliate of Empower Retirement, LLC; Empower Funds, Inc.; and registered investment adviser Empower Advisory Group, LLC. This material is for informational purposes only and is not intended to provide investment, legal or tax recommendations or advice.

Plan Participation Guide

It’s your future. Own it.

OMNI & TSACG Compliance Services

Plan Participation Guide

What you will find in your Plan Participation Guide

Dear Employee,

Our goal at U.S. OMNI & TSACG Compliance Services is to make your life easier by ensuring your employer's supplemental retirement plan is administered properly and by ensuring that you have the resources you need to take full advantage of the opportunity to participate.

Your employer has placed the administration of their plan(s) in our hands, and this is not a responsibility we take lightly. It is our promise to you that no matter where you are at in life - actively working, nearing retirement, or retired - we will dedicate the time and effort to simplify how you access your account and manage your contributions.

This Plan Participation Guide was developed to provide resource information, but as you dive deeper into the management of your retirement accounts, you may find that you still have questions. Don't worry. We are here to help. Our Customer Service Representatives are available to assist with distribution submission and approval questions as well as salary reduction agreement submission questions. The contact information for our teams can be found later in this document.

Welcome to your benefits plan. We are happy you are here.

Sincerely,
U.S. OMNI & TSACG Compliance Services

US OMNI & TSACG Compliance Services

Meet U.S. OMNI & TSACG Compliance Services

Making sure you receive the financial wellness resources you deserve.

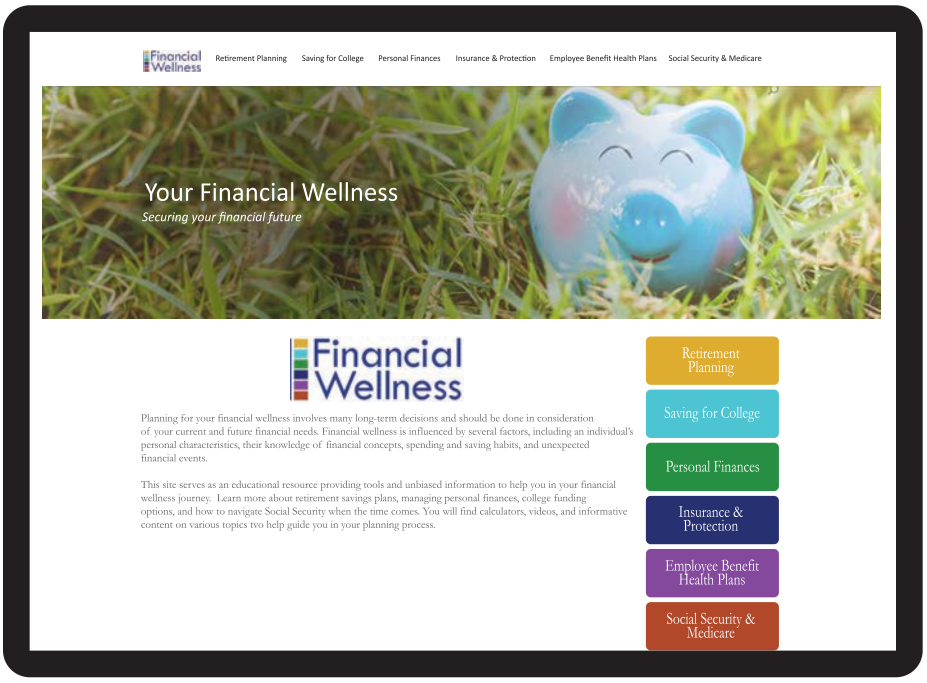
At our core, we are a group of people helping people achieve their retirement planning and wellness goals. We are just like you. We work hard so that one day we, too, can have a secure financial future.

We understand that financial preparedness should be stress-free, so we are here to make sure your plan is administered properly. We take care of the administrative details of your plan, such as remitting contributions, authorizing distribution requests, and answering everyday questions.

Since 1996, we have grown dramatically while remaining focused on what truly matters most: people. Whether it is you, your employer, our employees, or our community, we focus on connecting people with financial wellness solutions that lead to a more fulfilled life.

Many of these solutions can be found in our Financial Wellness Center. The center program contains planning modules that allow you to watch, read, or plan utilizing numerous planning calculators, videos, and educational articles. Center resources can be accessed 24/7.

Financial Wellness Center: https://usrbpfinancialwellness.com/



OMNI & TSACG Compliance Services

Getting Started

An introduction to your plan.

Understanding Your Plan

A 403(b) or 457(b) plan allows you to save for retirement on a tax-deferred basis. Your contributions are voluntary, and you can choose the amount based on your retirement goals. For more specific information on your employer's plan design, please reference the Meaningful Notice, which can be accessed by searching for your employer forms and information at https://www.tsacg.com/individual/plan-sponsor/.

Why Wait?

Simply put, waiting could cost you. You might ask: What difference could ten years make? Let's say you wanted to build a $500,000 nest egg to help bridge the gap of your current retirement savings plan. If you start at age 25, you will need to contribute at least $1,500 annually to a plan earning 10% in order to meet your goal; however, if you were to wait ten years to start, you will need to contribute at least $4,400 annually to earn the same amount. The earlier you start, the more potential earnings you can enjoy later in life.

Online Resources

Once enrolled in the plan, you have 24/7 access to a variety of educational tools and plan resources online. Available in the FORMS or INDIVIDUAL sections at https://www.tsacg.com, your online access allows you to obtain plan forms, access guides and videos on how to use the website, view the plan's authorized investment providers, and so much more.

Submitting Distributions

Within just a few minutes, distribution requests can be submitted and approved using our Online Distribution System. This online system allows participants and advisors alike to gain immediate approval certification for eligible distributions. Further, all distribution requests may be submitted in this manner -- even those that require supporting documentation. U.S. OMNI & TSACG Compliance Services' Online Distribution System can be found on the homepage at https://www.tsacg.com, and is available 24/7. For more information on submitting distributions, please visit our website.

Submitting Salary Reduction Agreements

If this service is being utilized by your employer, you also have the ability to start, change, or stop a deduction at your convenience via our online Salary Reduction Agreement system. This system, which is available 24/7, will provide an immediate confirmation when the request has been submitted. The system also permits your financial advisor/representative to assist you in this process. Your employer's page on https://www.tsacg.com houses both a link to the online system and step-by-step instructions.

US OMNI & TSACG Compliance Services

Enrollment

You have decided to participate in the plan. Now what?

After reviewing your employer's 403(b) or 457(b) plan, you will likely want to take advantage of saving for retirement on a tax-deferred basis. Here are some tips on how to get started.

Pick Your Investment Provider

You will want to review your employer's list of authorized investment providers and determine where you want to invest your money. A complete list of your investment providers is available to you when you visit your employer's page on https://www.tsacg.com/individual/plan-sponsor/. Not sure which investment provider to choose? Review company marketing materials, consult with your financial advisor, or ask a trusted colleague or mentor if they work with an advisor or investment provider they would recommend.

Contact Your Chosen Investment Provider

Once you have decided on an investment provider or providers, be sure to contact them and establish an account.

Complete a Salary Reduction Agreement

Next, you simply complete a Salary Reduction Agreement (SRA) via the process defined by your employer. Your employer's page at https://www.tsacg.com/individual/plan-sponsor/ will either reflect the instructions to submit an SRA via U.S. OMNI & TSACG Compliance Services' online SRA system, and/or house an SRA which can be completed and submitted via the instructions provided by your employer.

What Happens Next?

Once you have submitted your SRA request, your employer will begin deducting your contribution amount from your paycheck and send the funds to your chosen investment provider or providers.

OMNI & TSACG Compliance Services

Participant Services - P.O. Box 4037 - Fort Walton Beach, FL 32549-4037

Choose the benefits that are right for you

LPVEC is pleased to have Colonial Life benefit counselors assist with enrollments.

The following voluntary benefits are available:

Disability insurance can replace a portion of your income to help make ends meet if you become disabled from a covered accident or covered sickness.

Accident insurance helps offset unexpected medical expenses that can result from a covered accidental injury.

Critical illness insurance can supplement your major medical coverage by providing a lump-sum benefit that you can use to pay costs related to a covered critical illness.

Term life insurance offers a predictable way to provide more coverage at more affordable prices during high-need years.

Whole life insurance provides long-term protection that can build cash value.

For more information please scan the QR code to sign up for an informational meeting with Stephanie:
S.DeChristofaro@NEEnrollment.com

With most of our benefits:

- Benefits are paid directly to you, unless you specify otherwise.
- You're paid regardless of any insurance you have with other companies.
- Coverage is available for your spouse and dependent children.

Colonial Life

Additional offerings

College Tuition Benefit provides guaranteed college scholarships, designed to benefit your children, grandchildren,nieces and nephews. Each child you enroll can earn up to 1 free year of college tuition at over 400+ colleges across the US.
See the list of schools at www.collegetuitionbenefit.com

Wellcard provides discounts on prescription drugs, discounts on medical and dental expenses, access to a telemedicine provider and medical bill consultation.

Terms and availability of service are subject to change. Services may not be available in all states.

ColonialLife.com

Flexible Spending Account

Why You'll Love It

- Can be used to pay for thousands of eligible medical expenses.
- You can use your entire yearly contribution starting day one.
- A Grace Period or Rollover may be available to you. Check with your employer for more information.

▸ **myameriflex.com/participants**

An FSA can help you prepare for everyday healthcare needs

Use your FSA to pay for expenses such as:

- Deductibles
- Copays
- Prescriptions
- Orthodontia
- Teeth cleaning
- LASIK
- Glasses and contact lenses
- Band-aids
- Sunscreen
- Over-the-counter medicine
- Feminine menstrual care

2024 Contribution Limit: $3,200

For a full list of eligible expenses, go to

▸ **myameriflex.com/eligibleexpenses**

Flexible Spending Account

Flexible Spending Account

As part of your employer's benefit plan, you have the option to enroll in a flexible spending account (FSA) to save money on out-of-pocket healthcare expenses. Participating in an FSA is an easy way to pay for everyday health needs and unexpected medical emergencies.

What is an FSA?

An FSA is a tax-advantaged spending account for healthcare expenses. When you enroll in an FSA, you will choose an amount to contribute, tax-free, to pay for thousands of eligible expenses. Whether it's $1 or the IRS maximum of $3,200, you will have the flexibility to choose a contribution amount that you're comfortable with and makes sense for your situation. Your total contribution will be available to you on the first day of the plan year, providing a safety net should you need that money right away.

Eligible Expenses

You will get a debit card linked to your FSA that can be used for expenses such as:

- Prescriptions
- Over-the-counter medicine
- Glasses, contacts, and LASIK
- Dental services and procedures
- Copays and deductibles
- Flu shots
- And much more

$640 Rollover

You may have the option to roll over up to $640 of unused FSA funds remaining at the end of the plan year. If you need ideas for spending any unused funds, head over to FSAstore.com, where everything is FSA-eligible and you can pay with your Ameriflex card.

Grace Period

This is a 2.5 month period that immediately follows the end of the plan year in which you can submit claims for reimbursement using remaining FSA funds from the previous plan year.

Rollover vs. Grace Period

Please note that your employer will offer either a rollover or a grace period, not both. Your employer elects this option, so be sure to confirm with your employer whether your FSA has a rollover or a grace period.

Account Management and Customer Support

You can manage your account online at myameriflex.com or by downloading the Ameriflex mobile app. Both provide easy access to your account balance, transaction history, status of reimbursements, order replacement cards, and more.

For account-related questions, contact the Ameriflex Participant Services team at service@myameriflex.com, Monday - Friday: 7:00 AM to 8:00 PM CST and Saturday: 9:00 AM to 1:00 PM CST.

What to Expect and How to Submit Documentation for an Expense

Due to the tax-advantaged nature of your account, the IRS has guidelines in place to ensure that purchases made with the account are for eligible medical, dental, or vision expenses. As the administrator of your account, Ameriflex has controls in place to ensure you and your employer are always in compliance with IRS regulations.

The Ameriflex Debit Mastercard® will attempt to auto-verify all transactions instantly using stored copays provided by your employer. If the transaction cannot be auto-verified at the point of purchase, this is normally because the merchant's payment terminal can't distinguish if the transaction was for an eligible or ineligible service. It's important to note that most dental and vision charges will require documentation to verify the service was not cosmetic related.

If Ameriflex cannot auto-verify your expense, you will receive a notification asking for additional documentation such as an itemized receipt, Explanation of Benefits (EOB), or a letter of medical necessity. The documentation should show: name of the person who received the service or for whom the item was purchased, date(s) of service or purchase, the services that were rendered, name of the provider, and total cost of the expense. Please note that a standard credit card terminal receipt is not an acceptable form of documentation.

If you receive a request for additional documentation to verify an expense, complete the following steps on your desktop, tablet, or mobile device using the Ameriflex app.

1. Log into your Ameriflex account.
2. Locate the transaction that requires additional documentation.
3. Click Add Documents next to the specific transaction.
4. A new window appears.
5. Locate and select the documentation you'd like to upload. This can be a picture from your mobile device.
6. Follow the remaining window prompts on your screen to complete the uploading process.

Dependent Care Account

Why You'll Love It

- Makes daycare, nursery school, and elder care more affordable.
- Reduces your taxable income, saving you hundreds of dollars in tax savings each year.
- Submit one claim for a recurring expense (such as daycare) at the beginning of the year and get reimbursed every pay period.

▸ **myameriflex.com/participants**

A DCA allows you to set aside pre-tax money to help pay costs associated with the care of dependents.

You can use it to pay for services like:

- Daycare or elder care
- Before-school and after-school care
- Preschool and nursery school
- Private sitter
- Summer day camp
- Nanny service

Contribution Limits

$2,500 - Married couples filing separately
$5,000 - Single taxpayer OR married couples filing jointly

Dependent Care Account

Dependent Care Account

With a dependent care account (DCA), you can contribute up to $5,000 pre-tax per year to use on a child dependent under the age of 13 or dependents who are unable to care for themselves. Unlike a Flexible Spending Account, DCA funds can only be used as they are deposited into your account.

Eligible Expenses

You may be reimbursed only for care that enables you to work, go to school full-time, or look for work on a full-time basis. DCA funds can be used on expenses such as:

- Tuition for licensed daycare facility
- Preschool
- After-school programs
- Elder care
- Summer day camps
- In-home dependent care services

Account Management and Customer Support

You can manage your account online at myameriflex.com or by downloading the Ameriflex mobile app. Both provide easy access to your account balance, transaction history, status of reimbursements, order replacement cards, and more.

For account-related questions, contact the Ameriflex Participant Services team at 888.868.3539, Monday - Friday: 7:00 AM to 8:00 PM CST and Saturday: 9:00 AM to 1:00 PM CST.

Life comes with challenges.

Your Assistance Program is here to help.

Your Assistance Program can help you reduce stress, improve mental health, and make life easier by connecting you to the right information, resources, and referrals.

All services are free, confidential, and available to you and your family members. This includes access to short-term counseling and the wide range of services listed below:

Mental Health Sessions
Manage stress, anxiety, and depression, resolve conflict, improve relationships, overcome substance abuse, and address any personal issues.

Life Coaching
Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Financial Consultation
Build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identity theft, and saving for retirement or tuition.

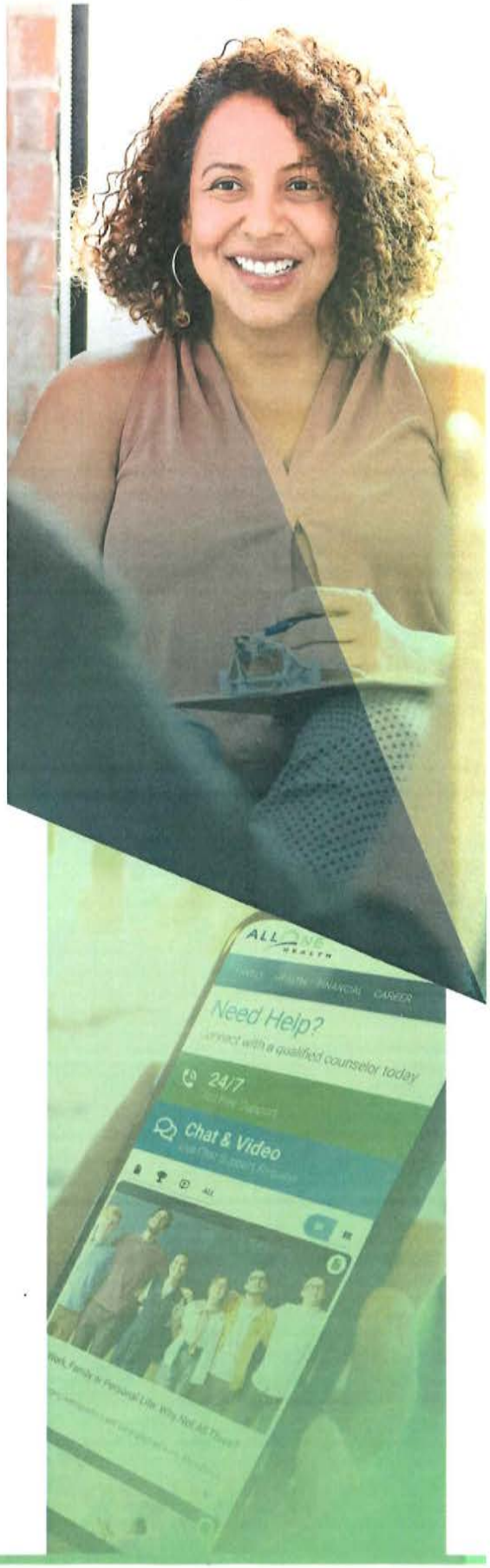
Legal Consultation
Get help with personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Work-Life Resources and Referrals
Obtain information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Personal Assistant
Save time with referrals for travel and entertainment, seeking professional services, cleaning services, home food delivery, and managing everyday tasks.

Medical Advocacy
Get help navigating insurance, obtaining doctor referrals, securing medical equipment or transportation, and planning for transitional care and discharge.

Member Portal and App
These digital tools enable you to access your benefits 24/7/365 with online requests and chat options. They also provide easy access to thousands of articles, webinars, podcasts, and tools covering total well-being.



Contact AllOne Health EAP
Call: 800.451.1834
Visit: www.allonehealtheap.com
Code: Ipvec

ALLONE HEALTH