BlueCross BlueShield

SUMMARY OF BENEFITS

ADVANTAGE BLUE® PREFERRED DEDUCTIBLE

Ginkgo Bioworks, Inc.

Plan-Year Deductible: $750/$1,500

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**.

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.

YOUR CHOICE

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$750** per member (or **$1,500** per family).

When You Choose Preferred Providers
Under this health care plan you receive benefits only when you use preferred providers, except in covered emergencies. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits. If the provider you use is not a preferred provider, you pay all costs even if the preferred provider refers you.

How to Find a Preferred Provider
To find a preferred provider:

- Look up a provider on Find a Doctor at **bluecrossma.com/findadoctor**. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**

When You Choose Non-Preferred Providers
You are covered for emergency care only. To receive coverage, any necessary follow-up care must be received from a preferred provider.

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical and prescription drug benefits is **$3,500** per member (or **$7,000** per family).

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your subscriber certificate (and riders, if any) for exact coverage details.

Utilization Review Requirements
Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your subscriber certificate for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

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

Domestic Partner Coverage
Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.

Covered Services	Your Cost
Preventive Care	
Well-child care exams, including routine tests, according to age-based schedule as follows: • Ten visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing, no deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	$150 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$25 per visit, no deductible $40 per visit, no deductible
Mental health or substance use treatment	$25 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit $25 per visit, no deductible
Diabetic management services (first two visits per calendar year*)	Nothing, no deductible
Chiropractors' office visits	$40 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	$40 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year**)	$40 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	$40 per visit, no deductible
Diagnostic X-rays and lab tests	$15 per service date after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$75 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible***
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$25 per visit†, no deductible $40 per visit†, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	10% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	10% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	10% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	10% coinsurance after deductible

* These diabetic services are for diabetes evaluation and management services, diabetic eye exams, or diabetic foot care.
** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
*** Cost share waived for one breast pump per birth, including supplies.
† Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible $10 for Tier 1 $15 for Tier 2 $40 for Tier 3 $75 for Tier 4
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible $15 for Tier 1 $25 for Tier 2 $80 for Tier 3 $150 for Tier 4
Specialty drugs when obtained from a designated specialty pharmacy (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1 $15 for Tier 2 $125 for Tier 5 $150 for Tier 6

* Generally, Tier 1 refers to preferred generic drugs; Tier 2 refers to non-preferred generic drugs; Tier 3 refers to preferred brand-name drugs; Tier 4 refers to non-preferred brand-name drugs; Tier 5 refers to preferred brand-name specialty drugs; Tier 6 refers to non-preferred brand-name specialty drugs.

** Cost share may be waived, reduced, or increased for certain covered drugs and supplies. Retail drugs are available in a 90-day supply at three times the standard retail cost share.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-424-0794 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your subscriber certificate for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your subscriber certificate for details.)	$150 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-424-0794, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.

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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, 25 Technology Place, Hingham, MA 02043; 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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PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

Arabic/ةيبر:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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