

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-564-5999. 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.bluecrossma.com/sbcglossary or call 1-800-564-5999 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 <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not applicable.	This <u>plan</u> does not have a <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-network</u> : Medical: \$4,600 /individual; \$9,200 /family. <u>Prescription drugs</u> : \$2,000 /individual; \$4,000 /family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Balance-billing</u> charges, health care this <u>plan</u> does not cover, <u>in-network</u> dental care and <u>in-network</u> vision care.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit.	20% <u>coinsurance</u> .	None.
	<u>Specialist</u> visit			
	<u>Preventive care/screening/immunization</u>	No charge.	20% <u>coinsurance</u> .	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge.	20% <u>coinsurance</u> .	None.
	Imaging (CT/PET scans, MRIs)	Hospital: \$200 <u>copay</u> /test. Freestanding facilities: no charge.	20% <u>coinsurance</u> .	Verify with <u>provider</u> whether service is provided at a hospital or freestanding facility.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com or by calling 1-800-966-5772.	Generic drugs	\$15 <u>copay</u> /prescription (Retail & Mail Order).	Not applicable. This <u>plan</u> does not use a <u>network</u> for <u>prescription drugs</u> .	No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is not medically appropriate). Limit: Retail: 30-day supply; Mail Order/CVS Pharmacy: 90-day supply. <u>Copays</u> for retail and mail order pharmacies are the same. This <u>plan</u> does not use a <u>network</u> for <u>prescription drugs</u> . You can fill prescriptions at any pharmacy. However, mail order/CVS Pharmacy is mandatory after two retail fills of maintenance drugs. Call Caremark Connect Specialty Pharmacy Services at 1-800-237-2767.
	Preferred brand drugs			
	Non-preferred brand drugs	\$25 <u>copay</u> /prescription. (Retail & Mail Order)		
	<u>Specialty drugs</u>			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital: \$200 <u>copay</u> /surgery. Ambulatory center: \$20 <u>copay</u> /surgery	20% <u>coinsurance</u> .	None.
	Physician/surgeon fees			
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit.	\$100 <u>copay</u> /visit.	<u>Copay</u> waived if admitted. Professional/physician charges may be billed separately.

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)	
	<u>Emergency medical transportation</u>	No charge.	10% <u>coinsurance</u> .	None.
	<u>Urgent care</u>	\$20 <u>copay</u> /visit.	20% <u>coinsurance</u> .	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay</u> /admission.	20% <u>coinsurance</u> .	<u>Preauthorization</u> required or benefits may be reduced or denied. Coverage limited to rate for a semi-private room.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /visit.	20% <u>coinsurance</u> .	None.
	Inpatient services	\$200 <u>copay</u> /admission.	20% <u>coinsurance</u> .	<u>Preauthorization</u> required or benefits may be reduced or denied. Contact Modern Assistance Programs (MAP) prior to admission at 617-774-0331 or 1-800-878-2004.
If you are pregnant	Office visits	No charge.	20% <u>coinsurance</u> .	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound)
	Childbirth/delivery professional services	\$200 <u>copay</u> /admission.	20% <u>coinsurance</u> .	None.
	Childbirth/delivery facility services			Coverage limited to rate for a semi-private room.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> required or benefits may be reduced or denied.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit.	20% <u>coinsurance</u> .	<u>Referral</u> required. Physical therapy and occupational therapy: <u>preauthorization</u> required for services continuing more than 8 weeks or benefits may be reduced or denied. Speech therapy: <u>preauthorization</u> required or benefits may be reduced or denied.
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	No charge.	20% <u>coinsurance</u> .	Limit: 90 days/year. <u>Preauthorization</u> required or benefits may be reduced or denied.

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)	
	<u>Durable medical equipment</u>	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> recommended to determine whether item is covered.
	<u>Hospice services</u>	No charge.	No charge.	<u>Preauthorization</u> required or benefits may be reduced or denied.
If your child needs dental or eye care	Children's eye exam	No charge up to \$60 <u>allowed amount</u> .	You pay 100% and request reimbursement of up to \$60 <u>allowed amount</u> .	Limit: 1 exam/2 years (applies to <u>in-network</u> exams). <u>In-network</u> benefits administered by Davis Vision. <u>Out-of-network</u> reimbursement is administered by the Fund Office.
	Children's glasses	No charge up to \$150 <u>allowed amount</u> .	You pay 100% and request reimbursement of up to \$150 <u>allowed amount</u> .	Limit: \$150/2 years (applies to <u>in-network</u> glasses). <u>In-network</u> benefits administered by Davis Vision. <u>Out-of-network</u> reimbursement is administered by the Fund Office.
	Children's dental check-up	No charge for preventive and diagnostic care.	No charge for preventive and diagnostic care. <u>Out-of-network providers</u> may balance bill.	Limit: \$1,000/year. Limit does not apply to preventive and diagnostic care. Administered by Delta Dental.

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.)

- Cosmetic surgery (except if required due to an accidental injury or following mastectomy)
- Custodial care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs (except as required by the ACA)

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

- Acupuncture (limit: \$300/year)
- Bariatric surgery
- Chiropractic care (limit: \$400/year)
- Dental care (Adult) (limit: \$1,000/year)
- Hearing aids (limit: \$1,600 for one hearing aid or \$3,200 for two hearing aids every 4 years)
- Non-emergency care when traveling outside the U.S. (see www.bcbsma.com)
- Routine eye care (Adult) (limit: 1 exam up to \$60/2 years and \$150 glasses/2 years)
- Routine foot care (limit: \$500/year non-surgical procedures or \$2,500/year for surgical procedures)

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: the Fund Office at 1-800-564-5999. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Massachusetts Division of Insurance Customer Services Division at (877) 563-4467 or <http://www.mass.gov/doi>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

—————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 pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copay \$20
- Hospital (facility) copay \$200
- Other cost sharing \$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	\$12,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$260
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$260

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 copay \$20
- Hospital (facility) copay \$200
- Generic prescription drugs copay \$15

This **EXAMPLE** event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,320
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,320

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

- The plan's overall deductible \$0
- Specialist copay \$20
- Emergency room copay \$100
- Other cost sharing \$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	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$240
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$240

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