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 plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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?	In-network: Medical: **$4,600**/individual; **$9,200**/family. Prescription drugs: **$2,000**/individual; **$4,000**/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?	Balance-billing charges, health care this plan does not cover, in-network dental care and in-network vision care.	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 www.bluecrossma.com/findadoctor or call 1-800-821-1388 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.

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	$20 copay/visit.	20% coinsurance.	None.
	Specialist visit			
	Preventive care/screening/ immunization	No charge.	20% coinsurance.	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.	None.
	Imaging (CT/PET scans, MRIs)	Hospital: $200 copay/test. Freestanding facilities: no charge.	20% coinsurance.	Verify with provider whether service is provided at a hospital or freestanding facility.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or by calling 1-800-966-5772.	Generic drugs	$15 copay/prescription (Retail & Mail Order).	$15 copay/prescription (Retail & Mail Order).	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. When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you pay the difference between the brand-name medication and the generic plus the generic copay. This applies to Retail and Mail Order. Does not apply if doctor indicates "No Substitutions" or "Dispense as Written" ("DAW"). Mail Order/CVS Pharmacy is mandatory after two retail fills of maintenance drugs.
	Preferred brand drugs	$25 copay/prescription. (Retail & Mail Order)	$25 copay/prescription. (Retail & Mail Order)	
	Non-preferred brand drugs	$25 copay/prescription. (Retail & Mail Order)	$25 copay/prescription. (Retail & Mail Order)	
	Specialty drugs	$15 copay/prescription for generic drugs; $25 copay/prescription for preferred brand and non-preferred brand drugs (available through Mail Order only).	Not covered	Call Caremark Connect Specialty Pharmacy Services at 1-800-237-2767.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital: $200 copay/ surgery. Ambulatory center: $20 copay/surgery	20% coinsurance.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$100 copay/visit.	$100 copay/visit.	Copay waived if admitted. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge.	10% coinsurance.	None.
	Urgent care	$20 copay/visit.	20% coinsurance.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission.	20% coinsurance.	Preauthorization 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 copay/visit.	20% coinsurance.	None.
	Inpatient services	$200 copay/admission.	20% coinsurance.	Preauthorization 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% coinsurance.	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound)
	Childbirth/delivery professional services	$200 copay/admission.	20% coinsurance.	None.
	Childbirth/delivery facility services			Coverage limited to rate for a semi-private room.

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 help recovering or have other special health needs	Home health care	No charge.	20% coinsurance.	Preauthorization required or benefits may be reduced or denied.
	Rehabilitation services Habilitation services	$20 copay/visit.	20% coinsurance.	Referral required. Physical therapy and occupational therapy: preauthorization required for services continuing more than 8 weeks or benefits may be reduced or denied. Speech therapy: preauthorization required or benefits may be reduced or denied.
	Skilled nursing care	No charge.	20% coinsurance.	Limit: 90 days/year. Preauthorization required or benefits may be reduced or denied.
	Durable medical equipment	No charge.	20% coinsurance.	Preauthorization recommended to determine whether item is covered.
	Hospice services	No charge.	No charge.	Preauthorization 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 allowed amount.	You pay 100% and request reimbursement of up to $60 allowed amount.	Limit: 1 exam/2 years (applies to in-network exams). In-network benefits administered by Davis Vision. Out-of-network reimbursement is administered by the Fund Office.
	Children's glasses	No charge up to $150 allowed amount.	You pay 100% and request reimbursement of up to $150 allowed amount.	Limit: $150/2 years (applies to in-network glasses). In-network benefits administered by Davis Vision. Out-of-network 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. Out-of-network providers 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

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 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: 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

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.

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$230
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$250**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$950
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$950**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

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