



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 bluecrossma.com/coverage-info.

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.com/sbcglossary or call **1-800-241-0803** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$0 in-network; \$250 member / \$500 family out-of-network.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Emergency room and emergency transportation.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> 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>?	\$1,000 member / \$2,000 family out-of-network.	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>?	Deductible, premiums, balance-billing charges, and health care this plan doesn't cover.	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 bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers. For pharmacy, go to express-scripts.com or call 1-877-543-7097.	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</u> charge 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> .



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	\$15 / visit	20% coinsurance	Deductible applies first for out-of-network
	<u>Specialist</u> visit	\$15 / visit; \$15 / chiropractor visit	20% coinsurance; 20% coinsurance / chiropractor visit	Deductible applies first for out-of-network
	<u>Preventive care/screening/immunization</u>	\$5 / visit (no cost for related routine lab tests and x-rays)	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency. 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	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	TeamstersCare & Mail \$5; Retail \$15 + 20% of remaining discounted Express Scripts cost	Not covered	TeamstersCare Pharmacies/Mail up to 90-day supply; Retail up to 30-day supply
	Preferred brand drugs	TeamstersCare & Mail \$15; Retail \$25 + 20% of remaining discounted Express Scripts cost	Not covered	Days supply same as generics; Prescriptions costing \$5,000 or more require approval
	Non-preferred brand drugs	Covered at retail only	Not covered	You pay brand copay + 20% of remaining cost of brand & cost difference for brand if generic available
	<u>Specialty drugs</u>	\$15 for 30-day supply	Not covered	TeamstersCare Pharmacies or Express Scripts Accredo only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first for out-of-network
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network

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 immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	Copayment waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$15 / visit	20% coinsurance	Deductible applies first for out-of-network
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission	20% coinsurance	Deductible applies first for out-of-network; total inpatient copayments will not exceed \$1,000 per member per calendar year; pre-authorization required
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Inpatient services	\$250 / admission	20% coinsurance	Deductible applies first for out-of-network; total inpatient copayments will not exceed \$1,000 per member per calendar year; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first for out-of-network; total inpatient copayments will not exceed \$1,000 per member per calendar year; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	\$250 / 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	<u>Home health care</u>	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	<u>Rehabilitation services</u>	\$15 / visit	20% coinsurance	Deductible applies first for out-of-network; limited to 20 visits per calendar year (other than for autism, home health care, and speech therapy)
	<u>Habilitation services</u>	\$15 / visit	20% coinsurance	Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	<u>Skilled nursing care</u>	\$250 / admission	20% coinsurance	Deductible applies first for out-of-network; limited to 100 days per calendar year; total inpatient copayments will not exceed \$1,000 per member per calendar year; pre-authorization required
	<u>Durable medical equipment</u>	No charge	20% coinsurance	Deductible applies first for out-of-network
	<u>Hospice services</u>	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% coinsurance for members with a cleft palate / cleft lip condition	Limited to members under age 18; deductible applies first for out-of-network

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.)

- Acupuncture
- Children's eye exam
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care - adult

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Hearing care and hearing aids, age 3 and up, at TeamstersCare Audiology Office with no charge
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine foot care (only for patients with systemic circulatory disease)
- Routine vision services through Davis Vision (from Versant Health)
- Weight loss programs (\$150 per calendar year per policy)
- Fitness programs (\$150 per calendar year per policy)
- Dental coverage through TeamstersCare Dental Offices

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 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 Member Service number listed on your ID card or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.) You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp. Send prescription drug benefit appeals to Express Scripts, PO Box 66587, St. Louis, MO 63166-6597, Attn: Administrative Appeals, 1-800-946-3979.

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.

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	\$250
■ 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	\$12,713
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$273
Coinsurance	\$4

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$337
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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	\$15
■ Primary care visit copay	\$15
■ 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	\$7,389
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$1,504
Coinsurance	\$1,197

What isn't covered

Limits or exclusions	\$55
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The total Joe would pay is	\$2,756
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Jacquie's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	\$0
■ Specialist visit copay	\$15
■ 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	\$1,925
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In this example, Jacquie would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$175
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Jacquie would pay is	\$175
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The plan would be responsible for the other costs of these EXAMPLE covered services.

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