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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 in-network; $250 member / $500 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. Emergency room and emergency transportation.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	$1,000 member / $2,000 family out-of-network.	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?	Deductible, copayments for out-of-network, 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. For pharmacy, go to **express-scripts.com** or call 1-877-543-7097.	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	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Specialist visit	$15 / visit; $15 / chiropractor visit; $15 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	$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; 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 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

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 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 $3,000 or more at retail 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
	Specialty drugs	$15 for 30-day supply	Not covered	TeamstersCare Pharmacies or Express Scripts Accredo only
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	20% coinsurance	Deductible applies first for out-of-network; copayments limited to $1,000 per calendar year for all inpatient admissions; pre-authorization 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)	
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization 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 mental health, behavioral health, or substance abuse services	Outpatient services	$15 / 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	$250 / admission	20% coinsurance	Deductible applies first for out-of-network; copayments limited to $1,000 per calendar year for all inpatient admissions; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first for out-of-network; copayments limited to $1,000 per calendar year for all inpatient admissions; 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	$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	Home health care	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Rehabilitation services	$15 / visit for outpatient services; $250 / admission for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first for out-of-network; limited to 20 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); copayments limited to $1,000 per calendar year for all inpatient admissions; limited to 100 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$15 / 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	$250 / admission	20% coinsurance	Deductible applies first for out-of-network; copayments limited to $1,000 per calendar year for all inpatient admissions; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	20% coinsurance	Deductible applies first for out-of-network
	Hospice services	No charge	20% coinsurance	Deductible applies first for out-of-network; 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	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	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 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.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing care and hearing aids, age 3 and up, at TeamstersCare Audiology Office at no charge
- 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 vision services through Davis Vision (from Versant Health)
- Dental coverage through TeamstersCare Dental Offices
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)
- Fitness 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 1-800-472-2689 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, P.O. Box 66587, St. Louis, MO 63166-6597, Attn: Administrative Appeals, 1-800-946-3979.

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	$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

Mia'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	**$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.