



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: |
|--|---|---|
| <u>What is the overall deductible?</u> | \$0 | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| <u>Are there services covered before you meet your deductible?</u> | No. | You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services. |
| <u>Are there other deductibles for specific services?</u> | No. | You don't have to meet <u>deductibles</u> for specific services. |
| <u>What is the out-of-pocket limit for this plan?</u> | Not applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| <u>What is not included in the out-of-pocket limit?</u> | Not applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| <u>Will you pay less if you use a network provider?</u> | Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> . 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 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. |
| <u>Do you need a referral to see a specialist?</u> | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |

| 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 | Not covered | A telehealth <u>cost share</u> may be applicable |
| | <u>Specialist</u> visit | \$15 / visit; \$15 / chiropractor visit; \$15 / acupuncture visit | Not covered | Limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. 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 | Not covered | <u>Pre-authorization</u> required for certain services |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | <u>Pre-authorization</u> required for certain services |
| 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 Pharmacies \$5; Mail \$5; Retail \$10 | Not covered | TeamstersCare Pharmacies/Mail up to 90-day supply; Retail up to 30-day |
| | Preferred brand drugs | TeamstersCare Pharmacies \$15; Mail \$15; Retail \$20 | 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 plus difference in cost for brand if generic available |
| | <u>Specialty</u> drugs | \$15 for a 30-day supply | Not covered | Covered at TeamstersCare Pharmacies or Express Scripts Accredo |

| 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 | Not covered | <u>Pre-authorization</u> required for certain services |
| | Physician/surgeon fees | No charge | Not covered | <u>Pre-authorization</u> required for certain services |
| If you need immediate medical attention | <u>Emergency room care</u> | \$75 / visit | \$75 / visit | <u>Copayment</u> waived if admitted or for observation stay |
| | <u>Emergency medical transportation</u> | No charge | No charge | None |
| | <u>Urgent care</u> | \$15 / visit | \$15 / visit | Out-of-network coverage limited to out of service area; a telehealth <u>cost share</u> may be applicable |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | <u>Pre-authorization</u> / authorization required for certain services |
| | Physician/surgeon fees | No charge | Not covered | <u>Pre-authorization</u> / authorization required for certain services |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$15 / visit | Not covered | A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | Inpatient services | No charge | Not covered | <u>Pre-authorization</u> / authorization required for certain services |
| If you are pregnant | Office visits | No charge | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | No charge | Not covered | |

| 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 | Not covered | <u>Pre-authorization</u> required for certain services |
| | <u>Rehabilitation services</u> | \$15 / visit for outpatient services; No charge for inpatient services | Not covered | Limited to 60 outpatient visits per calendar year (other than for autism, Down syndrome, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | <u>Habilitation services</u> | \$15 / visit | Not covered | Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services |
| | <u>Skilled nursing care</u> | No charge | Not covered | Limited to 100 days per calendar year; <u>pre-authorization</u> required |
| | <u>Durable medical equipment</u> | No charge | Not covered | None |
| | <u>Hospice services</u> | No charge | Not covered | <u>Pre-authorization</u> 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 | Not covered | 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
- Non-emergency care when traveling outside the U.S.
- 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
- Routine vision services through Davis Vision (from Versant Health)
- Dental coverage through TeamstersCare Dental Offices and Dental Blue Freedom
- 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.ccio.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)

| | |
|--|-----|
| ■ <u>The plan's overall deductible</u> | \$0 |
| ■ <u>Delivery fee copay</u> | \$0 |
| ■ <u>Facility fee copay</u> | \$0 |
| ■ <u>Diagnostic tests copay</u> | \$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:

| <u>Cost sharing</u> | |
|---------------------|------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|-----------------------------------|-------------|
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$70 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|--|------|
| ■ <u>The plan's overall deductible</u> | \$0 |
| ■ <u>Specialist visit copay</u> | \$15 |
| ■ <u>Primary care visit</u> | \$15 |
| ■ <u>Diagnostic tests copay</u> | \$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:

| <u>Cost sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$900 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|-----------------------------------|--------------|
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$920 |

Mia's Simple Fracture

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

| | |
|--|------|
| ■ <u>The plan's overall deductible</u> | \$0 |
| ■ <u>Specialist visit copay</u> | \$15 |
| ■ <u>Emergency room copay</u> | \$75 |
| ■ <u>Ambulance services copay</u> | \$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:

| <u>Cost sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$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.

® Registered Marks of the Blue Cross and Blue Shield Association. © 2026 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

003800675 (08/25) LK