



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 www.local4funds.org. 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>?	\$250 member / \$500 family.	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. Preventive and prenatal care, most office visits, therapy visits, mental health visits, certain imaging.	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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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>?	\$5,000 member / \$10,000 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>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . You are protected from <u>balance-billing</u> in certain cases, like when you have an emergency or visit a <u>network facility</u> but are unexpectedly treated by an <u>out-of-network provider</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 <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You must use a <u>provider</u> in the <u>plan's network</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 (in-person & telehealth)	Not covered	None
	Specialist visit	\$15 / visit (in-person & telehealth); \$15 / chiropractor visit; \$15 / acupuncture visit / \$15 homeopathy or massage therapy	Not covered	Limited to 20 chiropractor visits per calendar year; limited to 20 acupuncture visits per calendar year; limited to \$1,000 combined maximum per person for homeopathy or massage therapy.
	Preventive care/screening/immunization	No charge	Not covered	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	Diagnostic test (x-ray, blood work)	10% coinsurance for hospitals; \$15 for other providers	Not covered	Deductible applies first for hospitals; pre-authorization may be required.
	Imaging (CT/PET scans, MRIs)	10% coinsurance for hospitals; \$50 for other providers	Not covered	Deductible applies first for hospitals; copayment applies per category of test / day; pre-authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.local4funds.org	Generic drugs	\$10 copay , retail \$20 copay , mail order	Difference between out-of-network cost and in-network cost, minus copay.	Retail is 30-day supply; mail order (available at CVS pharmacy or delivery) is 90-day supply.
	Preferred brand drugs	\$30 copay , retail \$60 copay , mail order	Difference between out-of-network cost and in-network cost, minus copay.	Retail is 30-day supply; mail order (available at CVS pharmacy or delivery) is 90-day supply.
	Non-preferred brand drugs	\$50 copay , retail \$100 copay , mail order	Difference between out-of-network cost	Retail is 30-day supply; mail order (available at CVS pharmacy or delivery) is 90-day supply.

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)	
			and in-network cost, minus copay.	
	<u>Specialty drugs</u>	30% <u>coinsurance</u> , reduced to \$0 if you utilize PrudentRx Copay Program. If drug is not covered under PrudentRx Copay Program, you pay \$200 <u>copay</u> , retail.	Not covered	Contact PrudentRx Copay Program at 1-800-578-4403. <u>Specialty drugs</u> are limited to a 30-day supply. Prior authorization may be required.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services. <u>Coinsurance</u> may be waived for select procedures if Blue Distinction Centers are utilized.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services.
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Deductible</u> applies first
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Deductible</u> applies first
	<u>Urgent care</u>	\$15 / visit (in-person & telehealth)	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required. <u>Coinsurance</u> may be waived for select procedures if Blue Distinction Centers are utilized.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit (in-person & telehealth)	Not covered	<u>Pre-authorization</u> required for certain services. Partial-Day Hospitalization and/or Intensive Outpatient Treatment require preapproval from Modern Assistance Programs (MAP). Penalty: \$250 or denial of admission if not medically necessary.
	Inpatient services	10% <u>coinsurance</u>	Not covered	Requires preapproval from MAP. Penalty: \$250 or denial of admission if not medically necessary.
If you are pregnant	Office visits	No charge for prenatal care (in-person & telehealth); 10% <u>coinsurance</u> for postnatal care	Not covered	<u>Deductible</u> applies first except for prenatal care; <u>cost sharing</u> does not apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not covered	

If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required.
	<u>Rehabilitation services</u>	\$15 / visit (in-person & telehealth)	Not covered	Limited to 100 visits per calendar year (other than for <u>home health care</u> and speech therapy).
	<u>Habilitation services</u>	\$15 / visit (in-person & telehealth)	Not covered	Rehabilitation therapy coverage limits apply.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year (combined with rehabilitation hospital); <u>pre-authorization</u> required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies.
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services.
If your child needs dental or eye care	Children's eye exam	\$15 / visit	Amounts above \$57	One eye exam per year.
	Children's glasses	No charge	Amounts above \$47 for single vision; \$79 for bifocal; \$113 for trifocal lenses	One pair of glasses per year.
	Children's dental check-up	No charge	No charge	Limited to two (2) check-ups per year.

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
- Massage therapy/homeopathic coverage above \$1,000 combined annual maximum
- Routine foot care
- Long-term care
- Skilled nursing above 100 days per calendar year benefit maximum
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Acupuncture (20 visits per calendar year)
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Dental care (adult)
- Hearing aids
- Routine eye care (adult)
- Weight loss programs (\$175 per calendar year per policy)
- Infertility treatment (Progyny)

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 1-800-241-0803 or contact your **plan** sponsor. (A **plan** sponsor is usually the member's employer or organization that provides group health coverage to the member.)

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 **\$250**
- Delivery fee coinsurance **10%**
- Facility fee coinsurance **10%**
- Diagnostic tests copay **\$15**

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$1,470

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible **\$250**
- Specialist visit copay **\$15**
- Primary care visit copay **\$15**
- Diagnostic tests 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$460
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Joe would pay is	\$590

Mia's Simple Fracture

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

- The plan's overall deductible **\$250**
- Specialist visit copay **\$15**
- Emergency room coinsurance **10%**
- Ambulance services coinsurance **10%**

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$540

Note: These numbers assume the patient does not participate in the plan's diabetes wellness program, in which case costs shown here may be higher. For more information about the diabetes wellness program, please contact CVS Transform Diabetes Care at 1-800-378-0772.

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