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 deductible?	$250 member / $500 family.	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. Preventive and prenatal care, most office visits, therapy visits, and mental health visits, certain diagnostic tests and imaging.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	$5,000 member / $10,000 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?	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. You are protected from balance-billing in certain cases, like when you have an emergency or visit a network facility but are unexpectedly treated by an out-of-network provider.
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.	This plan uses a provider network. You must use a provider in the plan's network. 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 (in-person & telehealth)	Not covered	Cost share waived for services at a Limited Service Clinic.
	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. Copayment applies per category of test/day; 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, COSTCO, 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, COSTCO, 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)	
	Non-preferred brand drugs	$50 copay, retail $100 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, COSTCO, or delivery) is 90-day supply.
	Specialty drugs	30% coinsurance, reduced to $0 if you utilize PrudentRx Copay Program. If drug is not covered under PrudentRx Copay Program, you pay $200 copay, retail.	Not covered	Contact PrudentRx Copay Program at 1-800-578-4403. Specialty drugs are limited to a 30-day supply. Prior 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Deductible applies first; pre-authorization required for certain services.
	Physician/surgeon fees	10% coinsurance	Not covered	Deductible applies first; pre-authorization required for certain services.
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Deductible applies first.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Deductible applies first.
	Urgent care	$15 / visit (in-person & telehealth)	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Deductible applies first; pre-authorization required for certain services. Coinsurance for inpatient hospitalization fees may be waived for select procedures if Blue Distinction Centers are utilized.
	Physician/surgeon fees	10% coinsurance	Not covered	Deductible applies first; pre-authorization required for certain services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 / visit (in-person & telehealth)	Not covered	Pre-authorization required for certain services.
	Inpatient services	10% coinsurance	Not covered	Deductible applies first; pre-authorization / authorization required for certain services.
If you are pregnant	Office visits	No charge for prenatal care (in-person & telehealth); 10% coinsurance for postnatal care	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	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	Home health care	10% coinsurance	Not covered	Deductible applies first; pre-authorization required.
	Rehabilitation services	$15 / visit for outpatient services (in-person & telehealth); 10% coinsurance for inpatient services	Not covered	Deductible applies first except for outpatient services; limited to 100 outpatient visits per calendar year (other than for autism, home health care and speech therapy); limited to 100 days per calendar year for inpatient admissions (combined with skilled nursing facility); pre-authorization required for certain services.
	Habilitation services	$15 / visit (in-person & telehealth)	Not covered	Outpatient Rehabilitation therapy coverage limits apply.
	Skilled nursing care	10% coinsurance	Not covered	Deductible applies first; limited to 100 days per calendar year (combined with rehabilitation hospital); pre-authorization required.
	Durable medical equipment	10% coinsurance	Not covered	Deductible applies first; cost share waived for one breast pump per birth, including supplies.
	Hospice services	10% coinsurance	Not covered	Deductible applies first; pre-authorization 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 with EyeMed provider.
	Children's glasses	No charge	Amounts above $47 for single vision; $79 for bifocal; $113 for trifocal lenses	One pair of glasses per year via EyeMed.
	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
- Private-duty nursing
- Long-term care
- Non-emergency care when traveling outside the U.S.

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)
- Routine foot care (only for patients with systemic circulatory disease)
- 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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$50
Coinsurance	$1,100
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$460
Coinsurance	$0
What isn't covered	
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$80
Coinsurance	$200
What isn't covered	
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. If you participate in the program, you may be able to lower your costs. 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.