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?	**$300** member / **$600** 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. Prescription drugs, emergency room care, and the following in-network services: primary care and specialist visits, preventive care, urgent care, outpatient mental health services, prenatal services, outpatient rehabilitation services, habilitation services, and children's dental check-ups.	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?	Yes. **$50** dental deductible per individual per calendar year for basic and major services only (in-network and out-of-network combined).	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For medical benefits, **$3,000** member / **$6,000** family; and for prescription drug benefits, **$1,000** member / **$2,000** 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.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number	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

Important Questions	Answers	Why This Matters:
	on your ID card for a list of network providers.	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	$20 copay / visit; deductible does not apply	20% coinsurance plus charges above allowed amount	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Specialist visit	$20 copay / visit; deductible does not apply	20% coinsurance plus charges above allowed amount	Limited to 12 acupuncture visits per calendar year; includes telehealth benefits, as applicable
	Preventive care/screening/immunization	No charge; deductible does not apply	20% coinsurance	Limited to age-based schedule and / or frequency; includes telehealth benefits, as 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)	10% coinsurance	30% coinsurance	Preauthorization may be required or benefits will be denied
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization may be required or benefits will be denied

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 bluecrossma.org/medication	Generic drugs	$10 copay / retail supply or $20 / mail service supply	Not covered	Deductible does not apply. Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; preauthorization required for certain drugs or benefits will be denied
	Preferred brand drugs	$25 copay / retail supply or $50 / mail service supply	Not covered	
	Non-preferred brand drugs	$40 copay / retail supply or $80 / mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; preauthorization required for certain drugs or benefits will be denied
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / admission	20% coinsurance plus charges above allowed amount	Preauthorization required for certain services or benefits will be denied
	Physician/surgeon fees	No charge; deductible does not apply	20% coinsurance plus charges above allowed amount	Preauthorization required for certain services or benefits will be denied
If you need immediate medical attention	Emergency room care	$100 / visit; deductible does not apply	$100 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	10% coinsurance; deductible does not apply	10% coinsurance; deductible does not apply	None
	Urgent care	$20 copay / visit; deductible does not apply	20% coinsurance plus charges above allowed amount	Includes telehealth benefits, as applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization / authorization required for certain services or benefits will be denied
	Physician/surgeon fees	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization / authorization required for certain services or benefits will be denied

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	$20 copay / visit; deductible does not apply. No charge for intensive outpatient treatment and partial hospitalization; deductible does not apply	20% coinsurance plus charges above allowed amount for office visits, intensive outpatient treatment and partial hospitalization	Includes telehealth benefits, as applicable; preauthorization required for certain services or benefits will be denied
	Inpatient services	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization / authorization required for certain services or benefits will be denied
If you are pregnant	Office visits	No charge for prenatal care; deductible does not apply. 10% coinsurance for postnatal care	20% coinsurance for prenatal care plus charges above allowed amount; 30% coinsurance for postnatal care plus charges above allowed amount	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); includes telehealth benefits, as applicable
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance plus charges above allowed amount	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance plus charges above allowed amount	

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	30% coinsurance plus charges above allowed amount	Preauthorization required or benefits will be denied
	Rehabilitation services	$20 copay / visit for outpatient services; deductible does not apply. 10% coinsurance for inpatient services	20% coinsurance for outpatient services plus charges above allowed amount; 30% coinsurance for inpatient services plus charges above allowed amount	Limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; includes telehealth benefits, as applicable; preauthorization required for certain services or benefits will be denied
	Habilitation services	$20 copay / visit; deductible does not apply	20% coinsurance plus charges above allowed amount	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; includes telehealth benefits, as applicable
	Skilled nursing care	10% coinsurance	30% coinsurance plus charges above allowed amount	Limited to 100 days per calendar year; preauthorization required or benefits will be denied
	Durable medical equipment	10% coinsurance	30% coinsurance plus charges above allowed amount	In-network cost share waived for one breast pump per birth, including supplies (20% coinsurance for out-of-network)
	Hospice services	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization required for certain services or benefits will be denied

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	No charge; deductible does not apply	No charge up to $100, then 100%; deductible does not apply	Limited to one exam every other calendar year. Separately administered by EyeMed.
	Children's glasses	No charge; deductible does not apply	No charge up to $250, then 100%; deductible does not apply	Limited to one pair every other calendar year. Separately administered by EyeMed.
	Children's dental check-up	No charge; dental deductible does not apply	Charges above the allowed amount; dental deductible does not apply	Limited to one check-up twice per calendar year. Separately administered by BCBSMA.

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
- Long-term care
- Private-duty nursing

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
- Dental care (Adult) ($1,500 per member per calendar year; $1,000 lifetime for orthodontia, enhanced dental benefits for certain dental care services are available for members who have been diagnosed with qualifying conditions)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger; $1,000 per ear every 36 months, regardless of age)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per family unit for qualified weight loss programs; limit not applicable to ACA preventive services)
- Routine eye care (Adult) (every other calendar year: one exam, one pair of glasses/contact lenses, and one pair of safety glasses for members)

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 Blue Cross Blue Shield of Massachusetts at 1-800-472-2689 or call the I.U.O.E. Local 98 Health and Welfare Plan at 1-888-441-1922. You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp. In addition, you may contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **http://www.dol.gov/ebsa/healthreform**.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al [**711**].
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 [**711**].
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [**711**].
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf [**711**] uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [**711**].
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni [**711**].
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye [**711**].
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang [**711**]

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	$300
■ Delivery fee coinsurance	10%
■ Facility fee coinsurance	10%
■ Diagnostic tests coinsurance	10%

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	$300
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,370**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$300
■ Specialist visit copay	$20
■ Primary care visit copay	$20
■ Diagnostic tests coinsurance	10%

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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	$300
■ Specialist visit copay	$20
■ Emergency room copay	$100
■ 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	$0
Copayments	$200
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$290**

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