This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bluecrossma.com or by calling **1-800-217-7878.** A complete SPD can be found at www.teamsters170hwf.com.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** PCP / Plan-Approved; **$300** member / **$600** family Self-Referred. Does not apply to emergency room, emergency transportation. Pharmacy copays do not apply toward deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For medical benefits, **$2,000** member / **$4,000** family for PCP/Plan-Approved medical, and for prescription drug benefits, **$1,000** member / **$2,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor or call **1-800-217-7878** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, PCP / Plan-Approved level of benefits only.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		PCP / Plan-Approved	Self-Referred	
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 Self Referred; family or general practitioner, internist, pediatrician, geriatric specialist and nurse practitioner
	Specialist visit	$20 / visit	20% coinsurance	Deductible applies first for Self-Referred
	Other practitioner office visit	$20 / chiropractor visit	20% coinsurance / chiropractor visit	Deductible applies first for Self-Referred; limited to 20 visits per calendar year
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for Self-Referred; GYN exam limited to one exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first for Self-Referred
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		PCP / Plan-Approved	Self-Referred	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available in the BCBSMA "Your Pharmacy Program" at www.bluecrossma.com and/or in the BCBSMA Pharmacy Benefit Handbook at www.teamsters170hwf.com	Generic drugs	$10 / retail or mail service supply	$10 / retail or mail service supply	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs ; pre-authorization required for certain drugs
	Preferred brand drugs	$15 / retail or mail service supply	$15 / retail or mail service supply	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and may be higher if generic available; pre-authorization required for certain drugs
	Non-preferred brand drugs	$35 / retail or mail service supply	$35 / retail or mail service supply	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and may be higher if generic available; pre-authorization required for certain drugs
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Applicable cost share (generic, preferred, non-preferred)	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services
If you need immediate medical attention	Emergency room services	$100 / visit	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	—— none ——
	Urgent care	$15 /visit PCP, OB,NP,PA $20 / visit other covered providers	20% coinsurance	Deductible applies first for Self-Referred

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		PCP / Plan-Approved	Self-Referred	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required
	Physician/surgeon fee	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required
	Substance use disorder outpatient services	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services
	Substance use disorder inpatient services	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Deductible applies first for Self-Referred
	Delivery and all inpatient services	No charge	20% coinsurance	Deductible applies first for Self-Referred

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		PCP / Plan-Approved	Self-Referred	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required
	Rehabilitation services	$20 / visit for physical and occupational therapy; $15 / visit for speech therapy	20% coinsurance	Deductible applies first for Self-Referred; limited to 60 visits per calendar year for PCP / Plan-Approved (other than for autism, home health care, and speech therapy); pre-authorization required for certain services
	Habilitation services	$20 / visit for physical and occupational therapy; $15 / visit for speech therapy	20% coinsurance	Deductible applies first for Self-Referred; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first for Self-Referred; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	30% coinsurance	50% coinsurance	Deductible applies first for Self-Referred; PCP / Plan-Approved; cost share waived for one breast pump per birth
	Hospice service	No charge	20% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		PCP / Plan-Approved	Self-Referred	
If your child needs dental or eye care	Eye exam	No charge – Benefits are "Excepted Benefits" and are covered through a Davis Vision Plan. See Att #10 of SPD.	70% co-insurance	Once every year through Davis Vision
	Glasses	No charge – Benefits are "Excepted Benefits" and are covered through a Davis Vision Plan. See Att #10 of SPD.	No coverage outside of Davis Vision's Frame Collection	Once every year through Davis Vision. Must choose from Davis Vision's Frame Collection for $0 copayment. Other limitations may apply
	Dental check-up	No charge-Benefits are "Excepted Benefits" and are covered through a BCBSMA Dental Plan. See Att #8 & #9 of SPD.	Amount billed by provider above allowed amount	Covered through dental plans

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-term care
- Non-Emergency Care When Traveling Outside the US
- Private-duty nursing
- Routine foot care (only for patients with systemic circulatory disease)
- Self-Referred Infertility Treatment

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limited to 20 visits per calendar year)
- Dental Care (Adult and Children): Benefits are "Excepted Benefits" through BCBSMA Dental Plans. Please see Att # 8 & #9 of SPD (Dental Blue Freedom Summary of Benefits)
- Hearing aids (see Benefit Description and Riders)
- Infertility Treatment (Referral required, not covered for Self-Referred)
- Routine eye care (Adult and Children): Benefits are "Excepted Benefits". Coverage through Davis Vision. Please see Att #10 of SPD (Vision Care Benefit Description)
- Weight Loss and Fitness programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiiłné t'áá jííkeh béésh bee' hane'jį T'áá doolé'é bina'íshdiłkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

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 page.