

 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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 781-272-1000 or 800-342-3792. 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 www.dol.gov/ebsa/healthreform or call 781-272-1000 or 800-342-3792 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-network</u> : \$250/individual; \$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. <u>Preventive services</u> , <u>prescription drugs</u> , dental and vision are covered before you meet your <u>deductible</u> .	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> ?	Medical: \$6,350/individual; \$12,700/family <u>Prescription drugs</u> : \$1,000/individual; \$2,000/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>Balance-billing</u> charges, COBRA <u>premiums</u> , penalties for failure to obtain <u>preauthorization</u> 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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbs.com or call 800-810-2583 for a list of <u>network providers</u> . Call E4 at 800-522-6763 for a list of mental health and substance abuse <u>network providers</u> .	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 full cost if you use an <u>out-of-network provider</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> .
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 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit.	Not covered.	None.
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit.	Not covered.	None.
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered.	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.	Genetic testing: limit \$2,500/individual/year.
	Imaging (CT/PET scans, MRIs)	MRIs: \$100 <u>copay</u> /test. CT/PET scan: \$20 <u>copay</u> /test.	Not covered.	None.
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	Retail: \$5 <u>copay</u> /prescription. Mail order: \$10 <u>copay</u> /prescription.	Same as <u>in-network</u> plus charges above <u>allowed amount</u> .	<u>Deductible</u> does not apply. Retail: limit 30-day supply. Mail order: limit 90-day supply
	Preferred brand drugs	Retail: \$15 <u>copay</u> /prescription. Mail order: \$30 <u>copay</u> /prescription.	Same as <u>in-network</u> plus charges above <u>allowed amount</u> .	Retail: after 3 refills of same <u>prescription drug</u> , subject to 50% <u>coinsurance</u> .
	Non-preferred brand drugs	Retail: \$25 <u>copay</u> /prescription. Mail order: \$50 <u>copay</u> /prescription.	Same as <u>in-network</u> plus charges above <u>allowed amount</u> .	No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). Step Therapy Program may be required for certain <u>prescription drugs</u> (you may be required to try a generic drug before a brand name drug).
	<u>Specialty drugs</u>	Same as non-specialty drugs.	Same as non-specialty drugs.	Certain drugs may be subject to <u>preauthorization</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per surgery.	Not covered.	<u>Preauthorization</u> may be required for some procedures. Benefits not covered where <u>preauthorization</u> is required and not obtained.
	Physician/surgeon fees	\$30 <u>copay</u> /visit.	Not covered.	
If you need immediate medical attention	<u>Emergency room care</u>	<u>Physician services</u> : \$20 <u>copay</u> /visit. First 3 visits/individual/year: \$150 ER facility <u>copay</u> /visit. Thereafter: \$300 ER facility <u>copay</u> /visit.	Same as <u>in-network</u> plus charges above <u>allowed amount</u> .	ER facility <u>copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	No charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per trip.	No charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per trip.	None.
	<u>Urgent care</u>	\$20 <u>copay</u> /visit.	Not covered.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per admission.	Not covered.	Coverage limited to rate for semi-private room. <u>Preauthorization</u> required for coverage. Benefits not covered where <u>preauthorization</u> is required and not obtained.
	Physician/surgeon fees	<u>Physician services</u> : no charge. <u>Surgeon services</u> : \$30 <u>copay</u> /visit.	Not covered.	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health office visits: \$20 <u>copay</u> /visit. Substance abuse services: no charge. Other outpatient services: no charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per course of treatment.	Not covered.	Other outpatient services: <u>Preauthorization</u> required for coverage. Benefits not covered where <u>preauthorization</u> is required and not obtained.
	Inpatient services	No charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per admission.	Not covered.	Coverage limited to rate for semi-private room. <u>Preauthorization</u> required for coverage. Benefits not covered where <u>preauthorization</u> is required and not obtained.
If you are pregnant	Office visits	\$20 <u>copay</u> /visit.	Not covered.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per admission.	Not covered.	Coverage limited to rate for semi-private room. <u>Preauthorization</u> required for coverage of stay of more than 48 hours (96 hours for cesarean delivery). Benefits not covered where <u>preauthorization</u> is required and not obtained.
	Childbirth/delivery facility services			
If you need help recovering or have other special health	<u>Home health care</u>	No charge.	Not covered.	Limit: 90 visits/year. <u>Preauthorization</u> required for coverage. Benefits not covered where <u>preauthorization</u> is required and not obtained.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
needs	<u>Rehabilitation services</u>	Outpatient: \$20 <u>copay</u> /visit. Inpatient: no charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per admission.	Not covered.	None.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit.	Not covered.	Speech, occupational, and physical therapy combined limit: 60 visits/year. Applied behavioral analysis for dependent children age 1-6 with Autism Spectrum Disorder limit: 20 hours/week. <u>Preauthorization</u> required for coverage. Benefits not covered where <u>preauthorization</u> is required and not obtained.
	<u>Skilled nursing care</u>	No charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per admission.	Not covered.	Limit: 100 days/year. <u>Preauthorization</u> required for coverage. Benefits not covered where <u>preauthorization</u> is required and not obtained.
	<u>Durable medical equipment</u>	No charge up to \$5,000/year. Thereafter 15% <u>coinsurance</u> .	Not covered.	Scooters and motorized wheelchairs covered up to \$2,500. <u>Preauthorization</u> may be required for coverage of certain items. Benefits not covered where <u>preauthorization</u> is required and not obtained.
	<u>Hospice services</u>	No charge.	Not covered.	Limit: 6 months. <u>Preauthorization</u> required for inpatient services. Benefits not covered where <u>preauthorization</u> is required and not obtained.
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	Optometrist: No charge up to \$20 <u>allowed amount</u> . Ophthalmologist: No charge up to \$30 <u>allowed amount</u> .	Under age 19: limit 1 exam/12 months; age 19 and over: limit 1 exam/24 months. Separately administered by Davis Vision.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Children's glasses	No charge for certain lenses and frames. <u>Deductible</u> does not apply.	Lenses: No charge up to \$30 <u>allowed amount</u> . Frames: No charge up to \$20 <u>allowed amount</u> .	Under age 19: limit 1 pair glasses/12 months; age 19 and over: limit 1 pair glasses/24 months. Separately administered by Davis Vision.
	Children's dental check-up	No charge. <u>Deductible</u> does not apply.	No charge up to <u>allowed amount</u> .	Limit: 2 exams/12 months. Pre-treatment estimate recommended for services totaling \$300 or more. Separately administered by Delta Dental.

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 (except following accidental injury or mastectomy)
- Long-term care (except if admitted within 24 hours of hospital discharge)
- Private-duty nursing
- Weight loss programs (except in-network nutrition counseling and as required by ACA)

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

- Acupuncture (30 visits/year)
- Bariatric surgery (preauthorization required for coverage)
- Chiropractic care (30 visits/year)
- Dental care (Adult)
- Hearing aids (\$1,200 per hearing aid every 5 years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (see www.bcbs.com)
- Routine eye care (Adult)
- Routine foot care

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 Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 800-318-2596.

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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 781-272-1000 or 800-342-3792. You may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

-----*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 pre-natal care and a hospital delivery)

- The plan's overall deductible \$250
- OB/GYN copay \$20
- Hospital (facility) coinsurance 0%
- Other \$0

This EXAMPLE event includes services like:
 OB/GYN office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$320

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 copay \$30
- Hospital (facility) coinsurance 0%
- Other \$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	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$780
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,030

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

- The plan's overall deductible \$250
- Rehabilitation services copay \$20
- Hospital ER (facility) copay \$150
- Other \$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	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$350
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600