



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.carpentersfund.org](http://www.carpentersfund.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](http://bluecrossma.com/sbcglossary) or call 1-800-241-0803 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p>\$350 individual / \$700 family.</p>	<p>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>.</p>
<p><b>Are there services covered before you meet your <u>deductible</u>?</b></p>	<p>Yes. <u>In-network</u> office visits, <u>in-network</u> preventive services, <u>in-network</u> diagnostic tests and imaging, <u>in-network</u> prescription drugs, <u>in-network</u> outpatient surgery professional fees, outpatient surgery facility fees, <b>emergency room care</b>, <u>in-network</u> urgent care, <u>in-network</u> in patient surgeon/anesthesia professional fees, inpatient facility fees, <u>in-network</u> offices visits for mental health and substance abuse services, inpatient mental health and substance abuse services, <u>in-network</u> childbirth/delivery and anesthesia professional services, skilled nursing care, occupational therapy, <u>in-network</u> physical therapy and vision services are covered before you meet your <u>deductible</u></p>	<p>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>

Important Questions	Answers	Why This Matters:
What is the <b>out-of-pocket limit</b> for this <b>plan</b> ?	<u>In-network</u> and <u>out-of-network</u> medical: <b>\$3,000</b> member / <b>\$6,000</b> family. <u>In-network</u> prescription drugs: <b>\$3,600/individual; \$7,200/family</b>	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 <b>out-of-pocket limit</b> ?	<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> .
Will you pay less if you use a <b>network provider</b> ?	Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> 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 will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</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 <b>referral</b> to see a <b>specialist</b> ?	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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 copay/office visit or health center; deductible does not apply	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$15 copay/office visit or health center; deductible does not apply	20% <u>coinsurance</u> ;	None
	<u>Preventive care/screening/immunization</u>	No charge Deductible does not apply	20% <u>coinsurance</u>	Age and frequency limitations apply. 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.

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 a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	CT scans/MRIs at freestanding facility and PET scans: no charge and <u>deductible</u> does not apply CT scans/MRIs at hospital: \$150 <u>copay</u> /test and <u>deductible</u> does not apply	CT scans/MRIs at freestanding facility and PET scans: 20% <u>coinsurance</u> CT scans/MRIs at hospital: \$150 <u>copay</u> /test plus 20% <u>coinsurance</u>	<u>Copay</u> for CT scans/MRIs at hospital waived if no freestanding facility within 30-miles radius of covered individual's home
If you need drugs to treat your illness or condition More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	30% <u>coinsurance</u> Retail: \$10 minimum/\$20 maximum Mail order: \$25 minimum/\$50 maximum.	Not covered	Deductible does not apply Retail limit: 34-day supply. Mail order limit: 90-day supply
	Preferred brand drugs	30% <u>coinsurance</u> Retail: \$25 minimum/\$50 maximum Mail order: \$63 minimum/\$125 maximum.	Not covered	Mandatory mail order for maintenance medications after three retail fills. You pay copay plus difference in cost for brand name drugs where a generic is available
	Non-preferred brand drugs	30% <u>coinsurance</u> Retail: \$40 minimum/\$80 maximum Mail order: \$100 minimum/\$200 maximum.	Not covered	No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate)
	<u>Specialty drugs</u>	30% <u>coinsurance</u> \$150 minimum/\$300 maximum		<u>Deductible</u> does not apply. Information about specialty drugs is available at <a href="http://www.accredo.com">www.accredo.com</a>

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)	\$250 / admission, then 20% <u>coinsurance</u>	\$250 / admission, then 20% <u>coinsurance</u>	<u>Pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>None</u>
If you need immediate medical attention	<u>Emergency room care</u>	\$100 copay/visit <u>deductible</u> does not apply	\$100 copay/visit; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	No charge	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission, then 20% <u>coinsurance</u> <u>Deductible</u> does not apply	\$250 / admission, then 20% <u>coinsurance</u> <u>Deductible</u> does not apply	<u>Pre-authorization</u> required or services not covered
	Physician/surgeon fees	Surgeon and anesthesia: no charge and deductible does not apply. Other services: 20% <u>coinsurance</u> .	20% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$15 copay/visit and deductible does not apply Other outpatient services: 20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	\$250 / admission, then 20% <u>coinsurance</u> <u>Deductible</u> does not apply	\$250 / admission, then 20% <u>coinsurance</u> <u>Deductible</u> does not apply	<u>pre-authorization</u> required or services 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 are pregnant	Office visits	No charge Deductible does not apply	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for in-network <u>preventive services</u> or prenatal services. Depending on the type of services <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	Delivery and anesthesia: no charge and deductible does not apply. Other services: 20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	\$250 copay/ admission, then 20% <u>coinsurance</u> <u>Deductible</u> does not apply	\$250 copay/ admission, then 20% <u>coinsurance</u> <u>Deductible</u> does not apply	None
If you need help recovering or have other special health needs	<u>Home health care</u>	Within 7 days of hospital discharge: No charge Otherwise: 20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Pre-authorization</u> required or services not covered.
	<u>Rehabilitation services</u>	Physical/occupational therapy: \$15 <u>copay</u> /visit and <u>deductible</u> does not apply.	20% <u>coinsurance</u>	None
	<u>Habilitation services</u>	Speech therapy: 20% <u>coinsurance</u>		
	<u>Skilled nursing care</u>	\$250 / admission, then 20% <u>coinsurance</u>	\$250 / admission, then 20% <u>coinsurance</u>	<u>Pre-authorization</u> required or services not covered
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	15% <u>coinsurance</u>	<u>Pre-authorization</u> required for outpatient services or 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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge. <u>Deductible</u> does not apply	You pay 100% and apply for reimbursement of <u>allowed amount</u> up to \$50	One exam/12months Separately administered by Davis Vision
	Children's glasses	No charge. <u>Deductible</u> does not apply	You pay 100% and apply for reimbursement of <u>allowed amount</u>	Two pairs/12months. Separately administered by Davis Vision
	Children's dental check-up	Not covered	Not covered	Not covered

**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.)**

- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs (Except 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
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Hearing Aids (Limit \$1,500 per ear per year for individuals up to age 19; \$1,500 per ear per 3 years for individuals over age 19-Administered by HEARUSA)
- Non-emergency care when traveling outside the U.S. (see [www.bluecrossma.com](http://www.bluecrossma.com))
- Routine Eye Care (Adult) (Administered by Davis Vision)
- Routine foot care (only for patients with systemic circulatory disease)

**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](http://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](http://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](http://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](http://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](http://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 <u>plan's</u> overall <u>deductible</u>	\$350
■ Delivery fee <u>coinsurance</u>	20%
■ Facility fee <u>copay/coinsurance</u>	\$250/20%
■ <u>Diagnostic tests copay</u>	\$0

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$250
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$2,520</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist</u> visit <u>copay</u>	\$15
■ Primary care visit <u>copay</u>	\$15
■ <u>Diagnostic tests copay</u>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$150
<u>Coinsurance</u>	\$1,040
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,190</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist</u> visit <u>copay</u>	\$15
■ Emergency room <u>copay</u>	\$100
■ Ambulance services <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$220
<u>Coinsurance</u>	\$120
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$690</b>

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