




**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](http://www.dol.gov/ebsa/healthreform) or call 781-272-1000 or 800-342-3792 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| <b>What is the overall deductible?</b>                              | <u>In-network</u> : <b>\$250</b> /individual; <b>\$500</b> /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> .  |
| <b>Are there services covered before you meet your deductible?</b>  | Yes. <u>Preventive services</u> from <u>network providers</u> , <u>prescription drugs</u> , and dental and vision from <u>network providers</u> are covered before you meet your deductible.  | 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> |
| <b>Are there other deductibles for specific services?</b>           | No.   | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b> | Medical: <b>\$6,350</b> /individual; <b>\$12,700</b> /family<br><u>Prescription drugs</u> : <b>\$2,000</b> /individual; <b>\$4,000</b> /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.  |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>      | <u>Balance-billing</u> charges, COBRA <u>premiums</u> , penalties for failure to obtain <u>preauthorization</u> , health care this <u>plan</u> doesn't cover, and certain specialty pharmacy drugs that are considered non-essential health benefits (these are generally reimbursed by the manufacturer at no cost to you).                    | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| <b>Will you pay less if you use a <u>network provider</u>?</b>      | Yes. See <a href="http://www.bluecrossma.org">www.bluecrossma.org</a> or call 1-800-810-2583 for a list of <u>network providers</u> . Visit <a href="http://hmc.personaladvantage.com">hmc.personaladvantage.com</a> (code: malab) or call 1-800-522-6763 for a list of additional 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.   |

| Important Questions  | Answers | Why This Matters:  |
|--|---------|--|
| 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> . |

 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><br>(You will pay the least)  | <u>Out-of-Network Provider</u><br>(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 subject to Medical Policy Guidelines and may be subject to <u>preauthorization</u> .  |
|   | Imaging (CT/PET scans, MRIs)                     | MRIs: \$250 <u>copay</u> /test, unless performed at free-standing radiology facility/doctor's office, then no charge.<br>CT/PET scan: \$20 <u>copay</u> /test. | Not covered.   | The <u>copay</u> is waived if there is no free-standing facility within a 30 mile radius of your home.  |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> | Generic drugs                                    | 20% <u>coinsurance</u> .<br>Retail: \$10 minimum/\$30 maximum per prescription.<br>Mail order: \$20 minimum/\$60 maximum per prescription.                     | Same as <u>in-network</u> plus charges above <u>allowed amount</u> . | <u>Deductible</u> does not apply.<br>Retail: limit 30-day supply and up to 90-day supply for maintenance drugs filled at a CVS pharmacy. Mail order: limit 90-day supply.<br>Retail: after 3 refills of same <u>prescription drug</u> , you are responsible for the full cost of the prescription. Contact ESI if you have questions about drug quantity management (DQM).<br>If you receive a brand drug when a generic drug is available, you pay the |
|   | Preferred brand drugs                            | 20% <u>coinsurance</u> .<br>Retail: \$30 minimum/\$90 maximum per prescription.<br>Mail order: \$60 minimum/\$180 maximum per prescription.                    | Same as <u>in-network</u> plus charges above <u>allowed amount</u> . |   |

| Common Medical Event                    | Services You May Need                          | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)                           |   |
|   | Non-preferred brand drugs                      | 20% <u>coinsurance</u> .<br>Retail: \$50 minimum/\$150 maximum per prescription.<br>Mail order: \$100 minimum/\$300 maximum per prescription.                                    | Same as <u>in-network</u> plus charges above <u>allowed amount</u> .         | <u>coinsurance/copay</u> , plus the difference in cost between the brand and generic drug.<br>No charge for FDA-approved preventive medications (or brand name medications if a generic is not medically appropriate).<br>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). Certain drugs may be subject to <u>preauthorization</u> or coverage may be denied. <u>Includes a specialty pharmacy copay assistance program</u> . The cost of certain <u>specialty drugs</u> will be reimbursed by the manufacturer at no cost to you. You must participate in the SaveonSP program to receive your medications at no cost. |
|   | <u>Specialty drugs</u>                         | Same as non-specialty drugs.   | Same as non-specialty drugs.   |   |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center) | \$100 <u>copay</u> /procedure, then 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> .  | ER facility <u>copay</u> waived if admitted.  |
|   | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per ride.   | 10% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per ride. | None.   |
|   | <u>Urgent care</u>                             | \$20 <u>copay</u> /visit.  | Not covered.   | None.   |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|--|---|--|--|---|
|  |   | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | \$100 <u>copay</u> , then 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                    | Physician services: no charge.<br>Surgeon services: \$30 <u>copay</u> /visit.  | Not covered.                                       | None.   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | Mental health office visits: \$20 <u>copay</u> /visit.<br>Substance abuse office visits: no charge.<br>Other outpatient services: \$100 <u>copay</u> /admission, then 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.                                       | Some other outpatient services: <u>Preauthorization</u> required for coverage. Benefits not covered where <u>preauthorization</u> is required and not obtained. Call Uprise Health at 800-522-6763.                 |
|  | Inpatient services                        | \$100 <u>copay</u> /admission, then 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. Call Uprise Health at 800-522-6763. |
| <b>If you are pregnant</b>   | 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 | \$20 <u>copay</u> /visit.  | Not covered.                                       | Coverage limited to rate for semi-private room.   |

| Common Medical Event   | Services You May Need                 | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|---------------------------------------|--|--|--|
|  |                                       | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
|  | Childbirth/delivery facility services | \$100 <u>copay</u> /admission, then no charge up to \$20,000, then 15% <u>coinsurance</u> , up to an out-of-pocket maximum of \$2,000 per admission.   |  | <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.                       |
| If you need help recovering or have other special health needs | <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.   |
|  | <u>Rehabilitation services</u>        | Outpatient: \$20 <u>copay</u> /visit.<br>Inpatient: \$100 <u>copay</u> /admission, then 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.                                       | <u>Preauthorization</u> required for coverage of inpatient services. Benefits not covered where <u>preauthorization</u> is required and not obtained.  |
|  | <u>Habilitation services</u>          | \$20 <u>copay</u> /visit.  | Not covered.                                       | <u>Preauthorization</u> required for coverage of Applied Behavioral Analysis for Autism Spectrum Disorder. Benefits not covered where <u>preauthorization</u> is required and not obtained.                          |
|  | <u>Skilled nursing care</u>           | \$100 <u>copay</u> /admission, then 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.<br><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.<br><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.<br><u>Preauthorization</u> required for inpatient services. 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><br>(You will pay the least)                           | <u>Out-of-Network Provider</u><br>(You will pay the most) |  |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | No charge.<br><u>Deductible</u> does not apply.                               | Not covered.  | Under age 19: limit 1 exam/12 months; age 19 and over: limit 1 exam/24 months.<br>Separately administered by Davis Vision.                       |
|   | Children's glasses         | No charge for certain lenses and frames.<br><u>Deductible</u> does not apply. | Not covered.  | Under age 19: limit 1 pair glasses/12 months; age 19 and over: limit 1 pair glasses/24 months.<br>Separately administered by Davis Vision.       |
|   | Children's dental check-up | No charge.<br><u>Deductible</u> does not apply.                               | No charge up to <u>allowed amount</u> .                   | Limit: 2 exams/12 months.<br>Pre-treatment estimate recommended for services totaling \$300 or more.<br>Separately administered by Delta Dental. |

## Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)                                  |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Cosmetic surgery (except following accidental injury or mastectomy)</li></ul>   | <ul style="list-style-type: none"><li>• Long-term care (except if admitted within 24 hours of hospital discharge)</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Weight loss programs (except <u>in-network</u> nutritional counseling and as required by ACA, and specific programs offered by the plan)</li></ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)   |  |   |
| <ul style="list-style-type: none"><li>• Acupuncture (30 visits/year)</li><li>• Bariatric surgery (<u>preauthorization</u> required for coverage)</li><li>• Chiropractic care (30 visits/year)</li></ul> | <ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Hearing aids (\$1,200 per hearing aid every 5 years)</li><li>• Infertility treatment</li></ul>                     | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li></ul>  |

**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](http://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](http://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 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, 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](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.

*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 <u>deductible</u>   | \$250 |
| ■ OB/GYN <u>copay</u>                    | \$20  |
| ■ Hospital (facility) <u>coinsurance</u> | 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*)

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

#### In this example, Peg would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$250        |
| <u>Copayments</u>                 | \$160        |
| <u>Coinsurance</u>                | \$50         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$20         |
| <b>The total Peg would pay is</b> | <b>\$480</b> |

### Managing Joe's Type 2 Diabetes

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

|  |       |
|--|-------|
| ■ The plan's overall <u>deductible</u>   | \$250 |
| ■ <u>Specialist copay</u>                | \$30  |
| ■ Hospital (facility) <u>coinsurance</u> | 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*)

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

#### In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$250          |
| <u>Copayments</u>                 | \$240          |
| <u>Coinsurance</u>                | \$1,010        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,500</b> |

### Mia's Simple Fracture

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

|  |       |
|--|-------|
| ■ The plan's overall <u>deductible</u> | \$250 |
| ■ <u>Rehabilitation services copay</u> | \$20  |
| ■ Hospital ER (facility) <u>copay</u>  | \$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*)

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

#### In this example, Mia would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$250        |
| <u>Copayments</u>                 | \$430        |
| <u>Coinsurance</u>                | \$120        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$800</b> |