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 deductible?	In-network: **$500**/individual; **$1,000**/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. Preventive services from network providers, prescription drugs, and dental and vision from network providers are covered before you meet your deductible.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: **$6,350**/individual; **$12,700**/family Prescription drugs: **$2,000**/individual; **$4,000**/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?	Balance-billing charges, COBRA premiums, penalties for failure to obtain preauthorization, health care this plan 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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bluecrossma.org or call 1-800-810-2583 for a list of network providers. Visit hmc.personaladvantage.com (code: malab) or call 1-800-522-6763 for a list of mental health and substance abuse network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the full cost if you use an out-of-network provider. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
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
		Network Provider (You will pay the least)	Out-of-Network Provider (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 and 10% coinsurance.	Not covered.	None.
	Specialist visit	$30 copay/visit and 10% coinsurance.	Not covered.	None.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	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.	Not covered.	Genetic Testing subject to Medical Policy Guidelines and may be subject to preauthorization.
	Imaging (CT/PET scans, MRIs)	MRI: $250 copay and 10% coinsurance, unless performed at free-standing radiology facility/doctor's office, then only 10% coinsurance. CT/PET scan: $20 copay/test and 10% coinsurance.	Not covered.	There is no copay if there is no free-standing facility available within a 30-mile radius of your home.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	20% coinsurance. Retail: $10 minimum/$30 maximum per prescription. Mail order: $20 minimum/$60 maximum per prescription	Same as in-network plus charges above allowed amount.	Deductible does not apply. 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. Retail: after 3 refills of same prescription drug, you are responsible for the full cost of the prescription. Contact ESI if you have questions about drug quantity management (DQM). If you receive a brand drug when a generic drug is available, you pay the coinsurance/copay, plus the difference in cost between the brand and generic drug. No charge for FDA-approved preventive medications (or brand name medications if a generic is not medically appropriate). Step Therapy Program may be required for certain prescription drugs (you may be required to try a generic drug before a brand name drug). Certain drugs may be subject to preauthorization or coverage may be denied. Includes a specialty pharmacy copay assistance program. The cost of certain specialty drugs 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.
	Preferred brand drugs	20% coinsurance. Retail: $30 minimum/$90 maximum per prescription. Mail order: $60 minimum /$180 maximum per prescription.	Same as in-network plus charges above allowed amount.	
	Non-preferred brand drugs	20% coinsurance. Retail: $50 minimum/$150 maximum per prescription. Mail order: $100 minimum/$300 maximum per prescription.	Same as in-network plus charges above allowed amount.	
	Specialty drugs	Same as non-specialty drugs.	Same as non-specialty drugs.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay, then 15% coinsurance, up to an out-of-pocket maximum of $5,000 per surgery.	Not covered.	Preauthorization may be required for some procedures. Benefits not covered where preauthorization is required and not obtained.
	Physician/surgeon fees	$30 copay/visit and 10% coinsurance.	Not covered.	
If you need immediate medical attention	Emergency room care	Physician services: $20 copay/visit. First 3 visits/individual/ year: $150 ER facility copay/visit. Thereafter: $300 ER facility copay/visit.	Same as in-network.	ER facility copay waived if admitted.

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)	
	Emergency medical transportation	20% coinsurance, up to an out-of-pocket maximum of $5,000 per ride.	20% coinsurance, up to an out-of-pocket maximum of $5,000 per ride.	None.
	Urgent care	$20 copay/visit and 10% coinsurance.	Not covered.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay, then 15% coinsurance, up to an out-of-pocket maximum of $5,000 per admission.	Not covered.	Coverage limited to rate for semi-private room. Preauthorization required for coverage. Benefits not covered where preauthorization is required and not obtained.
	Physician/surgeon fees	Physician services: no charge. Surgeon services: $30 copay/visit and 10% coinsurance.	Not covered.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health office visit: $20 copay/visit. Substance abuse office visits: no charge up to $500, then 10% coinsurance. Other outpatient services: $250 copay,, then 15% coinsurance, up to an out-of-pocket maximum of $5,000 per course of treatment.	Not covered.	Some other outpatient services: preauthorization required for coverage. Benefits not covered where preauthorization is required and not obtained. Call Uprise Health at 800-522-6763.
	Inpatient services	$250 copay, then 15% coinsurance, up to an out-of-pocket maximum of $5,000 per admission.	Not covered.	Coverage limited to rate for semi-private room. Preauthorization required for coverage. Benefits not covered where preauthorization is required and not obtained. Call Uprise Health at 800-522-6763.
If you are pregnant	Office visits	$20 copay/visit and 10% coinsurance.	Not covered.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).

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)	
	Childbirth/delivery professional services	$20 copay/visit.	Not covered.	Coverage limited to rate for semi-private room. Preauthorization required for coverage of stay of more than 48 hours (96 hours for cesarean delivery). Benefits not covered where preauthorization is required and not obtained.
	Childbirth/delivery facility services	$250 copay, then 15% coinsurance, up to an out-of-pocket maximum of $5,000 per admission.		
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Limit: 90 visits/year. Preauthorization required for coverage. Benefits not covered where preauthorization is required and not obtained.
	Rehabilitation services	Outpatient: $20 copay/visit and 10% coinsurance. Inpatient: $250 copay, then 15% coinsurance, up to an out-of-pocket maximum of $5,000 per admission.	Not covered.	Preauthorization required for coverage of inpatient services. Benefits not covered where preauthorization is required and not obtained.
	Habilitation services	$20 copay/visit and 10% coinsurance	Not covered.	Preauthorization required for coverage of Applied Behavioral Analysis for Autism Spectrum Disorder. Benefits not covered where preauthorization is required and not obtained.
	Skilled nursing care	$250 copay, then 15% coinsurance, up to an out-of-pocket maximum of $5,000 per admission.	Not covered.	Limit: 100 days/year. Preauthorization required for coverage. Benefits not covered where preauthorization is required and not obtained.
	Durable medical equipment	No charge up to $5,000/year, then 15% coinsurance.	Not covered.	Scooters and motorized wheelchairs covered up to $2,500. Preauthorization may be required for coverage of certain items. Benefits not covered where preauthorization is required and not obtained.
	Hospice services	No charge.	Not covered.	Limit: 6 months. Preauthorization required for inpatient services. Benefits not covered where preauthorization is required and not obtained.

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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered.	Under age 19: limit 1 exam/12 months; age 19 and over: limit 1 exam/24 months. Separately administered by Davis Vision.
	Children's glasses	No charge for certain lenses and frames. Deductible does not apply.	Not covered.	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. Deductible does not apply.	No charge up to allowed amount.	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) • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Weight loss programs (except in-network nutritional counseling and as required by ACA, and specific programs offered by the plan)

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	• 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 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.

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 deductible $500**
- **OB/GYN $20 copay and 10% coinsurance**
- **Hospital (facility) coinsurance 15%**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$310
Coinsurance	$1,280
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,110**

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

- **The plan's overall deductible $500**
- **Specialist $30 copay and 10% coinsurance**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$180
Coinsurance	$1,060
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,740**

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

- **The plan's overall deductible $500**
- **Rehabilitation services $20 copay and 10% coinsurance**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$430
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,090**

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