The Summary of Benefits and Coverage (SBC) document 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 617-524-1240 or 800-799-1240 or visit www.tuftshealthplan.com/carelink/dc35. 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 617-524-1240 or 800-799-1240 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers: **$0** Out-of-network providers: **$250**/individual/calendar year, **$500**/family/calendar year	In-network providers: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-network providers: 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	In-network providers: not applicable Out-of-network providers: Yes. Dental coverage and vision coverage are not subject to the deductible.	In-network providers: This plan does not have a deductible for in-network services. Out-of-network providers: This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for in-network services.
What is the out-of-pocket limit for this plan?	In-network providers: **$1,500**/individual/calendar year, **$3,000**/family/calendar year Out-of-network providers: **$3,000**/individual/calendar year, **$7,000**/family/calendar year	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments, balance billing charges, health care this plan doesn't cover, prescription drugs, penalties for failure to obtain pre-approval for services, and vision coverage and dental services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.tuftshealthplan.com/carelink/dc35 or call 617-524-1240 or 800-799-1240 for a list of in-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 most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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.
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
		In-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	$10 copay/visit	$10 copay/visit; 40% coinsurance	No charge for in-network telehealth visits through Teladoc.
	Specialist visit	$10 copay/visit	$10 copay/visit; 40% coinsurance	None
	Preventive care/screening/ immunization	$10 copay/visit No charge for some screenings and immunizations	$10 copay/visit; 40% coinsurance	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)	Non-hospital/no charge Hospital/10% coinsurance	40% coinsurance	Sleep study limit: dependents 18 and under must have pre-approval to avoid $1,000 penalty.
	Imaging (CT/PET scans, MRIs)	Non-hospital/no charge Hospital/10% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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.myallegiantrx.com	Generic drugs	Retail: $10 copay/30-day supply; $20 copay/90-day supply Mail Order: $20 copay/90-day supply	Not covered	Coverage limited to manufacturer's recommended dosage. If generic is available, coverage is limited to cost of generic. Prescription drug coverage is administered separately. Your cost sharing for prescription drug coverage is not included in the out-of-pocket limit. Call Optum Specialty at 1-855-427-4682 for pre-approval of specialty drugs.
	Brand drugs	Retail: $25 copay/30-day supply; $35 copay/90-day supply Mail Order: $35 copay/90-day supply	Not covered	
	Specialty drugs	Generic: $20 copay/ prescription Brand: $35 copay/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit;10% coinsurance	$100 copay/visit; 10% coinsurance	Contact Medical Certification Program at 800-558-9639 if admitted.
	Emergency medical transportation	10% coinsurance	40% coinsurance; except 10% coinsurance for air ambulance services	Must be nearest available facility; must be medically necessary and required to provide immediate treatment for injury, illness, or pregnancy. Air transportation limited to a life-threatening medical emergency only. Physician charges or wheelchair transport not covered. Pre-approval required for any transport other than air and land to avoid $1,000 penalty.
	Urgent care	$10 copay/visit; 10% coinsurance	$10 copay/visit; 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Pre-approval required to avoid $1,000 penalty. No coverage in excess of semi-private room rate.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Pre-approval required to avoid $1,000 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	$10 copay/visit; 40% coinsurance	No charge for in-network tele-mental health visits through Teladoc. No charge for in-network virtual counseling visits through MAP.
	Inpatient services	10% coinsurance	40% coinsurance	Pre-approval through MAP required to avoid $1,000 penalty. Call MAP at 1-800-878-2004. 25 days per admission for residential facility.
If you are pregnant	Office visits	$10 copay/visit	$10 copay/visit; 40% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	Pre-approval required to avoid $1,000 penalty for admissions in excess of 48 hours for vaginal delivery or 96 hours for cesarean section. No coverage in excess of semi-private room rate. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	Pre-approval required to avoid $1,000 penalty.
	Rehabilitation services	Rehabilitation facility: 10% coinsurance Occupational/physical therapy: no charge	40% coinsurance	Rehabilitation hospital limit: 25 days/admission Cardiac/pulmonary outpatient rehabilitation limit: 36 visits/calendar year. No coverage for vocational rehabilitation facility. Occupational/physical therapy: referral required; referring physician must recommend specific number of treatments; limit: 60 visits/calendar year; office visits not covered. Speech therapy coverage limited to speech loss/impairment due to injury, illness, pregnancy, cerebral vascular accident, congenital anomaly, or surgery, radiation therapy or other treatment that affects the vocal cords.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	10% coinsurance, but only if approved by CareAllies	40% coinsurance, but only if approved by CareAllies	Pre-approval by CareAllies required or no benefits provided.
	Durable medical equipment	No charge	40% coinsurance.	Pre-approval required to avoid $1,000 penalty for catheter supplies, colostomy/ostomy, diabetic supplies, insulin pumps (limit once/5 years), nebulizer (limit $250, 1/lifetime), custom foot orthotics (limit $250/calendar year), prosthetic appliances (limit: initial purchase), hair prosthesis (15% coinsurance, 1/calendar year), wigs (limit once/5 years due to alopecia or chemotherapy).
	Hospice services	Inpatient: 10% coinsurance; Outpatient: No charge	Inpatient and Outpatient: 40% coinsurance	Pre-approval required to avoid $1,000 penalty; must be for terminal illness; must have life expectancy of six months or less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	You will be reimbursed for up to $12.50.	Limit: 1 exam/12 months. Vision benefits administered separately.
	Children's glasses	No charge	You will be reimbursed for up to: Single vision lenses: $15 Bifocal lenses: $20 Trifocal lenses: $25 Frames: $10 Contact lenses: $52.50 Safety glasses: not covered	Limit: 2 pairs/12 months or 1 pair plus 12-month supply of Davis Vision contact lenses/12 months. Vision benefits administered separately by Davis Vision 800-999-5431.
	Children's dental check-up	No charge	Any amounts above allowed amount.	Pre-estimate recommended for charges exceeding $300. Limit: 2 check-ups/calendar year. Dental benefits administered separately by Delta Dental 800-872-0500 or visit www.deltadentalma.com.

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 an injury or mastectomy)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the United States
- Private duty nursing
- Routine foot care
- Skilled nursing care
- Weight loss programs (except bariatric surgery)

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

- Acupuncture (Limit: $1,600/year; pre-approval required for dependents 18 or younger; limit combined with chiropractic care)
- Bariatric surgery (10% coinsurance, pre-approval required or no coverage)
- Chiropractic care (Limit: $1,600/year; pre-approval required for dependents 18 or younger; limit combined with acupuncture)
- Dental care (Adult) (Limit $3,000/calendar year for services other than diagnostic and preventive)
- Hearing aids (once/5 years in-network)
- Infertility treatment (50% coinsurance)
- Routine eye care (Adult) (1 exam/24 months and 3 pairs glasses, including 1 pair of safety glasses if applicable; or 1 pair glasses and a 12-month supply of Davis Vision contact lenses/24 months)

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 1-800-318-2596.

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: the Fund Office at 617-524-1240 or 800-799-1240. 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-799-1240.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-799-1240.

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	$0
Specialist copay	$10
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,080**

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

The plan's overall deductible	$0
Specialist copay	$10
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$0
Copayments	$520
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$620**

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

The plan's overall deductible	$0
Specialist copay	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$0
Copayments	$150
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$330**

These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact the Fund Office at 617-524-1240 or 800-799-1240

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