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, call 1-800-528-1530. 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.mybenemax.com keyword: **BMAX** or call 1-800-528-1530 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care, prenatal care, certain value drugs, and preventive drugs.	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?	**$6,750** member / **$13,500** 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 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?	Premiums, balanced-billed charges, and health care this plan doesn't cover.	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. Visit www.bluecrossma.com/findadoctor or call the member service number on your ID Card for a list of 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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit	Not covered	Cost share waived for the first two diabetic PCP and / or specialist visits per calendar year.
	Specialist visit	$20 copay / visit; $20 copay / chiropractor & acupuncture visit	Not covered	Cost share waived for the first two diabetic PCP and / or specialist visits per calendar year; limited to 12 acupuncture visits per calendar year.
	Preventive care/screening/ immunization	No charge	Not covered	GYN exam limited to one exam per calendar year. 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)	No charge	Not covered	Preauthorization required for certain services.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Preauthorization required for certain services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com/medications	Generic drugs	No charge	Not covered	Up to 30-day (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; preauthorization required for certain drugs.
	Preferred brand drugs	No charge	Not covered	
	Non-preferred brand drugs	No charge	Not covered	
	Specialty drugs	No charge	Not covered	When obtained from a designated specialty pharmacy; preauthorization required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization required for certain services.
	Physician/surgeon fees	No charge	Not covered	Preauthorization required for certain services.
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$20 copay / visit	$20 copay / visit	Out-of-network coverage limited to out of service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization required.
	Physician/surgeon fees	No charge	Not covered	Preauthorization required.

* For more information about limitations and exceptions, see the plan or policy document at www.mybenemax.com keyword: **BMAX**

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Preauthorization required for certain services
	Inpatient services	No charge	Not covered	Preauthorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Preauthorization required.
	Rehabilitation services	$20 copay / visit	Not covered	Limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); preauthorization required for certain services
	Habilitation services	$20 copay / visit	Not covered	Limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); coverage limits waived for early intervention services for eligible children; preauthorization may be required for certain services.
	Skilled nursing care	No charge	Not covered	Limited to 100 days per calendar year; preauthorization required.
	Durable medical equipment	20% coinsurance	Not covered	Cost share waived for one breast pump per birth.
	Hospice services	No charge	Not covered	Preauthorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 12 months until the end of the month a member turns age 19
	Children's glasses	35% coinsurance	Not covered	Limited to one set of prescription lenses and / or frames or contact lenses per calendar year until the then end of the month a member turns age 19.
	Children's dental check-up	No charge	Not covered	Limited to twice per calendar year until the end of the month a member turns age 19.

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.)		
• Acupuncture • Cosmetic Surgery	• Dental care (adult) • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Bariatric surgery • Chiropractic care	• Hearing aids ($2,000 per ear every 36 months for members age 21 or younger) • Infertility treatment • Routine eye care- adult (one exam every 24 months)	• Routine Foot Care (only for patients with systemic circulatory disease) • Weight Loss Programs ($150 per calendar year per policy)

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 Massachusetts Division of Insurance at 1-877-563-4467 or 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 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 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 Office of Patient Protection at 1-800-436-7757.

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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-262-2583 TTY 711]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-262-2583 TTY 711.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-262-2583 TTY 711.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-262-2583 TTY 711.]

———————————*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
■ Delivery fee copay	$0
■ Facility fee copay	$0
■ Diagnostic tests copay	$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)*

Total Example Cost	**$12,713**

In this example, Peg would pay:

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

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 visit copay	$20
■ Primary care visit copay	$20
■ Diagnostic tests copay	$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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$255**

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$20
■ Emergency room copay	$0
■ Ambulance services copay	$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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$140**

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