
 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](http://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 <a href="#">deductible</a> ?	\$1,500 member / \$3,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.”
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , prenatal care, certain value drugs, and preventive drugs.	This <a href="#">plan</a> covers some items and services even if you haven’t yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don’t have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,750 member / \$13,500 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balanced-billed charges</a> , and health care this <a href="#">plan</a> doesn’t cover.	Even though you pay these expenses, they don’t count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> or call the member service number on your ID Card for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan’s network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider’s</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	This plan will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> / visit	Not covered	<a href="#">Deductible</a> applies first; <a href="#">cost share</a> waived for the first two diabetic PCP and / or <a href="#">specialist</a> visits per calendar year.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> / visit; \$20 <a href="#">copay</a> / chiropractor & acupuncture visit	Not covered	<a href="#">Deductible</a> applies first; <a href="#">cost share</a> waived for the first two diabetic PCP and / or <a href="#">specialist</a> visits per calendar year; limited to 12 acupuncture visits per calendar year.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	Not covered	GYN exam limited to one exam per calendar year. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required for certain services.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required for certain services.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bluecrossma.com/medications">www.bluecrossma.com/medications</a>	Generic drugs	No charge	Not covered	<a href="#">Deductible</a> applies first except for preventive drugs and certain value drugs; up to 30-day (90-day mail service) supply; <a href="#">cost share</a> may be waived for certain covered drugs and supplies; <a href="#">preauthorization</a> required for certain drugs.
	Preferred brand drugs	No charge	Not covered	
	Non-preferred brand drugs	No charge	Not covered	
	<a href="#">Specialty drugs</a>	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required for certain services.
	Physician/surgeon fees	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required for certain services.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 / visit	\$150 / visit	<a href="#">Deductible</a> applies first; <a href="#">copayment</a> waived if admitted or for observation stay.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	<a href="#">Deductible</a> applies first

\* For more information about limitations and exceptions, see the plan or policy document at [www.mybenemax.com](http://www.mybenemax.com) keyword: **BMAX**

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)	
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> / visit	\$20 <a href="#">copay</a> / visit	<a href="#">Deductible</a> applies first; out-of-network coverage limited to out of service area.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required.
	Physician/surgeon fees	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required for certain services
	Inpatient services	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required for certain services
<b>If you are pregnant</b>	Office visits	No charge	Not covered	<a href="#">Deductible</a> applies first except for prenatal care; <a href="#">cost sharing</a> does not apply for <a href="#">preventive</a> 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	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> / visit	Not covered	<a href="#">Deductible</a> applies first limited to 60 visits per calendar year (other than for autism, <a href="#">home health care</a> , and speech therapy); <a href="#">preauthorization</a> required for certain services
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> / visit	Not covered	<a href="#">Deductible</a> applies first limited to 60 visits per calendar year (other than for autism, <a href="#">home health care</a> , and speech therapy); coverage limits waived for early intervention services for eligible children; <a href="#">preauthorization</a> may be required for certain services.
	<a href="#">Skilled nursing care</a>	No charge	Not covered	<a href="#">Deductible</a> applies first; limited to 100 days per calendar year; <a href="#">preauthorization</a> required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies first; <a href="#">cost share</a> waived for one breast pump per birth.
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Deductible</a> applies first; <a href="#">preauthorization</a> required for certain services
	<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Not covered

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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)	
	Children's glasses	35% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies first; 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; <a href="#">deductible</a> does not apply	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](#).)**

- 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
- Acupuncture
- 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](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.

**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](#).

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**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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ 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*)

<b>Total Example Cost</b>	<b>\$12,713</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,560</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist</a> 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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,755</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist</a> visit copay	\$20
■ Emergency room copay	\$150
■ 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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$290
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,790</b>