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: **CHEX** or call 1-800-528-1530 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** member / **$2,000** 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, in-network preventive and prenatal care; prescription 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?	For medical benefits, **$5,450** member / **$10,900** family; and for prescription drug benefits, **$1,000** member / **$2,000** 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 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. See 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?	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)	In-Network Highest Cost Share	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	$15 copay / visit	$15 copay / visit	20% coinsurance	Deductible applies first; in-network cost share waived for the first two diabetic PCP and / or specialist visits per calendar year; a telehealth cost share may be applicable.
	Specialist visit	$15 copay / visit; $15 copay / chiropractor & acupuncture visit	$15 copay / visit; $15 copay / chiropractor & acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor & acupuncture visit	Deductible applies first; in-network cost share waived for the first two diabetic PCP and / or specialist visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable.
	Preventive care/screening/ immunization	No charge; deductible does not apply.	No charge; deductible does not apply.	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. 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	$100 for x-rays and $35 for lab tests for hospitals; no charge for other providers	20% coinsurance	Deductible applies first; copayment applies per category of test / day; preauthorization may be required
	Imaging (CT/PET scans, MRIs)	No charge	$450 for hospitals; no charge for other providers	20% coinsurance	Deductible applies first; copayment applies per category of test / day; preauthorization may be required

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	In-Network Highest Cost Share	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.bluecrossma.com/medications	Generic drugs	$15 / retail supply or $30 / mail order supply; deductible does not apply.		$30 / retail supply and all charges for mail order.	Up to 30-day retail (90-day mail order) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $60 / mail order supply; deductible does not apply.		$60 / retail supply and all charges for mail order.	
	Non-preferred brand drugs	$50 / retail supply or $150 / mail order supply; deductible does not apply.		$100 / retail supply and all charges for mail order.	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)		Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$1,000 / admission for hospitals; no charge for other providers	20% coinsurance	Deductible applies first; preauthorization required for certain services
	Physician/surgeon fees	No charge	No charge	20% coinsurance	Deductible applies first; preauthorization required for certain services
If you need immediate medical attention	Emergency room care	$250 / visit	$250 / visit	$250 / visit	Deductible applies first; copayment waived if admitted or for observation stay; $150 copayment applies after the first $2,000/$4,000
	Emergency medical transportation	No charge	No charge	No charge	Deductible applies first
	Urgent care	$15 copay / visit	$15 copay / visit	20% coinsurance	Deductible applies first
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$1,000 / admission for hospitals; no charge for other providers	20% coinsurance	Deductible applies first; preauthorization / authorization required.
	Physician/surgeon fees	No charge	No charge	20% coinsurance	Deductible applies first; preauthorization / authorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	In-Network Highest Cost Share	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay / visit	$15 copay / visit	20% coinsurance	Deductible applies first; a telehealth cost share may be applicable; preauthorization required for certain services.
	Inpatient services	No charge	$1,000 / admission for hospitals; no charge for other providers	20% coinsurance	Deductible applies first; preauthorization / authorization required for certain services.
If you are pregnant	Office visits	No charge	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) ; a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	$1,000 / admission for hospitals; no charge for other providers	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	20% coinsurance	Deductible applies first; preauthorization required.
	Rehabilitation services	$15 copay / visit for outpatient services; No charge for inpatient services	$50 copay / visit for general hospitals; $15 copay / visit for other providers; No charge for inpatient services	20% coinsurance	Deductible applies first; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; preauthorization required for certain services
	Habilitation services	$15 copay / visit	$50 copay / visit for general hospitals; $15 copay / visit for other providers	20% coinsurance	Deductible applies first; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable.
	Skilled nursing care	No charge	No charge	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	In-Network Highest Cost Share	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth, including supplies (20% coinsurance for out-of-network)
	Hospice services	No charge	No charge	20% coinsurance	Deductible applies first; preauthorization required for certain services.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	No charge; deductible does not apply	20% coinsurance	Deductible applies out-of-network; limited to one exam every 24 months.
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition; deductible does not apply	No charge for members with a cleft palate / cleft lip condition; deductible does not apply	20% coinsurance for members with a cleft palate / cleft lip condition;	Deductible applies out-of-network; limited to members under age 18

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.)

- Children's glasses
- Cosmetic Surgery
- Dental care (adult)
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (12 visits per calendar year) • Bariatric surgery • Chiropractic care • Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)	• Infertility treatment • Non-emergency care when traveling outside the US. • 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.*———————————

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

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	$1,000
■ 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	$1,000
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,120**

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	$1,000
■ Specialist visit copay	$15
■ Primary care visit copay	$15
■ 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	$910
Copayments	$1,005
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,970**

Mia's Simple Fracture

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

■ The plan's overall deductible	$1,000
■ Specialist visit copay	$15
■ Emergency room copay	$250
■ 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	$1,000
Copayments	$105
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,105**

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