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 1-800-822-2700 or visit us at http://www.bluecrossma.com/get-blue-ma/individuals-and-families/. 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.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $2,000 Individual / $4,000 Family. For out-of-network providers $4,000 Individual / $8,000 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. Services are covered before you meet your deductible. Contact Insurance provider for more details.	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 preventative services without cost sharing and before you meet your deductible. See a list of covered preventative 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 network providers $6,850 Individual / $13,700 Family. For out-of-network providers $7,500 Individual / $15,000 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?	Premiums, balance-billing charges, and health care this plan doesn't cover.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See http://www.bluecrossma.com/wps/portal/members/using-my-plan/doctors-hospitals/findadoctor/ or call 1-800-822-2700 for a list of 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.

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	$25 Copay and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
	Specialist visit	$55 Copay and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
	Preventive care/ screening/immunization	Copay: No Charge and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
If you have a test	Diagnostic test (x-ray, blood work)	$15 Copay after deductible and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	Copay: No Charge after deductible and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————

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 1-800-822-2700	Generic drugs (Tier 1)	$50 Copay and Coinsurance: Not Applicable	$100 Copay and Coinsurance: Not Applicable	——————none——————
	Preferred brand drugs (Tier 2)	$175 Copay and Coinsurance: Not Applicable	$350 Copay and Coinsurance: Not Applicable	——————none——————
	Non-preferred brand drugs (Tier 3)	$250 Copay and Coinsurance: Not Applicable	$500 Copay and Coinsurance: Not Applicable	——————none——————
	Specialty drugs (Tier 4)	$175 Copay and Coinsurance: Not Applicable	$350 Copay and Coinsurance: Not Applicable	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Copay: No Charge and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
	Physician/surgeon fees	Copay: No Charge and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room care	$350 Copay and Coinsurance: Not Applicable	$350 Copay and Coinsurance: Not Applicable	——————none——————
	Emergency medical transportation	Copay: No Charge and Coinsurance: Not Applicable	Copay: No Charge and Coinsurance: Not Applicable	——————none——————
	Urgent care	$55 Copay and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————

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 have a hospital stay	Facility fee (e.g., hospital room)	Copay: No Charge after deductible and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Physician/surgeon fee	Copay: No Charge and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
	Inpatient services	Copay: No Charge after deductible and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
If you are pregnant	Office visits	Please contact the health insurance company for more information	Please contact the health insurance company for more information	Please contact the health insurance company for more information
	Childbirth/delivery professional services	Please contact the health insurance company for more information	Please contact the health insurance company for more information	Please contact the health insurance company for more information
	Childbirth/delivery facility services	Please contact the health insurance company for more information	Please contact the health insurance company for more information	Please contact the health insurance company for more information

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 help recovering or have other special health needs	Home health care	Copay: No Charge and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	——————none——————
	Rehabilitation services	$55 Copay and Coinsurance: Not Applicable	$55 Copay and Coinsurance: Not Applicable	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Habilitation services	$55 Copay and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Skilled nursing care	Copay: No Charge and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Durable medical equipment	Copay: Not Applicable and 20% Coinsurance	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Hospice services	Copay: No Charge and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
If your child needs dental or eye care	Children's eye exam	Copay: No Charge and Coinsurance: Not Applicable	Copay: Not Applicable and 20% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Children's glasses	Copay: Not Applicable and 35% Coinsurance	Copay: Not Applicable and 55% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Children's dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Basic Dental Care - Adult
- Basic Dental Care - Child

- Cosmetic Surgery
- Dental Check-Up for Children
- Long-Term/Custodial Nursing Home Care
- Major Dental Care - Adult
- Major Dental Care - Child
- Orthodontia - Adult
- Orthodontia - Child
- Private-Duty Nursing
- Routine Dental Services (Adult)
- Routine Foot Care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Routine Eye Exam (Adult)
- Weight Loss Programs

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: State Department of Insurance at 617-521-7794 and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272). 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: State Department of Insurance at 617-521-7794.

Does this plan provide Minimum Essential Coverage? Please contact the health insurance company for more information.
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 Minimum Value Standards? Please contact the health insurance company for more information.
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 page.

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** **$ 2,000**
- **Specialist copayment** **$55**

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	**$ 7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$ 2,000
Copayments	$ 843
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$ 60
The total Peg would pay is	**$ 2,903**

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

- **The plan's overall deductible** **$ 2,000**
- **Specialist copayment** **$55**

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	**$ 5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$ 0
Copayments	$ 4,885
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$ 55
The total Joe would pay is	**$ 4,940**

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

- **The plan's overall deductible** **$ 2,000**
- **Specialist copayment** **$55**

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	**$ 1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$ 0
Copayments	$ 609
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$ 0
The total Mia would pay is	**$ 609**

Note: 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 costs. For more information about the wellness program, please contact: 1-800-822-2700.

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