The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows 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, see **www.bluecrossma.com/coverage-info**.

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.bluecrossma.com/sbcglossary** or call **1-800-782-3675** 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?	Not applicable.	This plan does not have an overall deductible.
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?	**$5,000** member / **$10,000** 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-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?	No.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	Your Cost	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 / visit	None
	Specialist visit	$20 / visit; $20 / chiropractor visit	None
	Preventive care/screening/immunization	No charge	Limited to age-based schedule and / or frequency. 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	None
	Imaging (CT/PET scans, MRIs)	No charge	None
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 service supply	Up to 30-day retail (90-day mail service) 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 service supply	
	Non-preferred brand drugs	$50 / retail supply or $100 / mail service supply	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	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	None
	Physician/surgeon fees	No charge	None
If you need immediate medical attention	Emergency room care	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	20% coinsurance	Cost share waived for air ambulance
	Urgent care	$20 / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	Pre-authorization required
	Physician/surgeon fees	No charge	Pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Pre-authorization required for certain services
	Inpatient services	$500 / admission	Pre-authorization required for certain services

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 • 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.)		
• 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 U.S. • 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)

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 prenatal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Delivery fee copay** **$0**
- **Facility fee copay** **$500**
- **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	$518
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$578**

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	$1,714
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,769**

Jacquie'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** **$100**
- **Ambulance services coinsurance** **20%**

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, Jacquie would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$119
What isn't covered	
Limits or exclusions	$0
The total Jacquie would pay is	**$319**

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

® Registered Marks of the Blue Cross and Blue Shield Association. © 2017 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.