



SUMMARY OF BENEFITS

NETWORK BLUE[®] NEW ENGLAND \$500 DEDUCTIBLE WITH HOSPITAL CHOICE COST SHARING

MIIA City of Peabody

Plan-Year Deductible: \$500/\$1,000

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND
BENEFITS



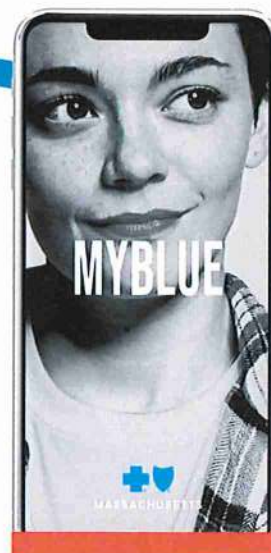
CLAIMS AND
BALANCES



DIGITAL
ID CARD

Sign in

Download the app, or create an account at bluecrossma.com.



Where you get care can impact what you pay for care.

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.

As a member in this plan, you will pay different levels of cost share (such as copayments and/or coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from any of the network general hospitals listed in this Summary of Benefits, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital (not listed in this Summary of Benefits) for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.com/hospitalchoice. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CARE

Your Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor; consult the Provider Directory; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Cost Share

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive inpatient services at or by "higher cost share hospitals," even if your PCP refers you. See the chart for your cost share.

Higher Cost Share Hospitals

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- | | |
|----------------------------------|---------------------------------|
| • Baystate Medical Center | • Boston Children's Hospital |
| • Brigham and Women's Hospital | • Cape Cod Hospital |
| • Dana-Farber Cancer Institute | • Fairview Hospital |
| • Massachusetts General Hospital | • UMass Memorial Medical Center |

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible for medical benefits is **\$500** per member (or **\$1,000** per family). Your deductible for prescription drug benefits is **\$100** per member (or **\$200** per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$2,500** per member (or **\$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

You are covered for certain medical and mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at wellconnection.com on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com, consult the Provider Directory, or call the Member Service number on your ID card.

Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Covered Services	Your Cost
Preventive Care	
Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by:	
• Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care	\$20 per visit, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$60 per visit, no deductible
Mental health or substance use treatment	\$10 per visit, no deductible
Telehealth services	
• Simple medical conditions	\$20 per visit, no deductible
• Mental health services	\$10 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year)	\$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$60 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 30 visits per calendar year for each type of therapy*)	\$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office or health center, when performed by:	
• Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care	\$20 per visit***, no deductible
• Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$60 per visit***, no deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$250 per admission after deductible
Inpatient Care (including maternity care) in:	
• Other general hospitals (as many days as medically necessary)	\$275 per admission after deductible†
• Higher cost share hospitals (as many days as medically necessary)	\$1,500 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$275 per admission, no deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** Cost share waived for one breast pump per birth.

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies** (up to a 30-day formulary supply for each prescription or refill)***	After deductible \$10 for Tier 1 \$30 for Tier 2 \$65 for Tier 3
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)***	After deductible \$25 for Tier 1† \$75 for Tier 2 \$165 for Tier 3
* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs. ** Specialty drugs available only when obtained from a designated specialty pharmacy. *** Cost share may be waived for certain covered drugs and supplies. † Certain generic medications are available through the mail order pharmacy at \$9, no deductible. For more information, go to bluecrossma.com/mail-order-pharmacy.	
Get the Most from Your Plan: Visit us at bluecrossma.com or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program	
Fitness Reimbursement: a program that rewards participation in qualified fitness programs This fitness program applies for fees paid to: a health club with cardiovascular and strength-training equipment; a fitness studio offering instructor-led group classes for cardiovascular and strength-training; or virtual fitness memberships or classes. (See your benefit description for details.)	\$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program This weight loss program applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.)	\$150 per calendar year per policy
 24/7 Nurse Line: A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583). No additional charge.	

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.com.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

* Registered Marks of the Blue Cross and Blue Shield Association. © 2021 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Printed at Blue Cross and Blue Shield of Massachusetts, Inc.

000915555 (04/21) JM



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, see www.emiaa.org. 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 bluecrossma.com/sbcglossary or call 1-800-782-3675 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$500 member / \$1,000 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. <u>Preventive care</u> , prenatal care, most office visits, certain mental health services, therapy visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without cost sharing and before you meet your deductible. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. For <u>prescription drugs</u> , \$100 member / \$200 family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For medical benefits, \$2,500 member / \$5,000 family; and for <u>prescription drug benefits</u> , \$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 own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing charges</u> , and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your plan pays (<u>balance billing</u>). Be aware, your network provider might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> 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 <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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 (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	Not covered	None
	<u>Specialist</u> visit	\$60 / visit; \$20 / chiropractor visit; \$60 / acupuncture visit	Not covered	Limited to 20 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year
	<u>Preventive care/screening/immunization</u>	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 <u>provider</u> if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$100	Not covered	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>bluecrossma.com/medications</u>	Generic drugs	\$10 / retail supply or \$25 / designated retail or mail order supply	Not covered	<u>Deductible</u> applies first; up to 30-day retail (90-day designated retail or mail order) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs
	Preferred brand drugs	\$30 / retail supply or \$75 / designated retail or mail order supply	Not covered	
	Non-preferred brand drugs	\$65 / retail supply or \$165 / designated retail or mail order supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	<u>Deductible</u> applies first; when obtained from a designated specialty pharmacy; <u>pre-authorization</u> required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	No charge	No charge	<u>Deductible</u> applies first
	<u>Urgent care</u>	\$60 / visit	\$60 / visit	Out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	\$275 / admission; \$1,500 / admission for certain hospitals	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 / visit	Not covered	<u>Pre-authorization</u> required for certain services
	Inpatient services	\$275 / admission; \$1,500 / admission for certain hospitals	Not covered	<u>Deductible</u> applies first for general hospitals; <u>pre-authorization</u> required for certain services
	Office visits	No charge	Not covered	<u>Deductible</u> applies first except for prenatal care; <u>cost sharing</u> does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$275 / admission; \$1,500 / admission for certain hospitals	Not covered	
	<u>Home health care</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	\$20 / visit	Not covered	Limited to 30 visits per type of therapy per calendar year (other than for autism, <u>home health care</u> , and speech therapy); <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$20 / visit	Not covered	Rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; <u>pre-authorization</u> required for certain services
	<u>Skilled nursing care</u>	20% coinsurance	Not covered	<u>Deductible</u> applies first; limited to 45 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth
	<u>Hospice services</u>	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	Not covered	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 <u>excluded services</u> .)	
- Children's glasses - 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 <u>plan document</u> .)	
- Acupuncture (12 visits per calendar year) - Bariatric surgery - Chiropractic care (20 visits per calendar year) - Hearing aids (\$5,000 per ear every 36 months)	- 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact 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. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

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 prenatal care and a hospital delivery)

- The plan's overall deductible \$500
- Delivery fee copay \$0
- Facility fee copay \$275
- 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 \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles*</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$860

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$500
- Specialist visit copay \$60
- 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 \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles*</u>	\$200
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

- The plan's overall deductible \$500
- Specialist visit copay \$60
- Emergency room copay \$100
- 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 \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

* Registered Marks of the Blue Cross and Blue Shield Association. © 2021 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.