BlueCross® BlueShield®

Blue Care Elect Deductible Plan℠

Plan-Year Deductible: $2,000/$4,000

Summary of Benefits

High Deductible Health Plan with Health Reimbursment Account (HDHP-HRA)

Woods Hole Oceanographic INSTITUTION

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

Your Choice

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your "in-network" benefits. You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits.

Your Deductible.

For some covered services, you must meet a plan-year deductible before benefits are provided. If you are not sure when your plan year begins, contact Blue Cross Blue Shield.

Your deductible is:

$2,000 for a member (or $**4,000** per family)

The following services are not subject to the deductible: in-network preventive health services and prescription drugs.

When You Choose Preferred Providers.

If you have not satisfied your deductible, your provider may ask you to pay the Blue Cross Blue Shield allowed charge for your care at the time of your visit. After the plan-year deductible has been met, you pay nothing for inpatient hospital, physician, and other provider covered services and some outpatient services. The plan-year deductible does not apply to preventive health services.

Please note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com/findadoctor**
- Call our Physician Selection Service at **1-800-821-1388**
- Select a provider online in the Blue Care Elect (PPO/EPO) network

When You Choose Non-Preferred Providers.

If you have not satisfied your deductible, your provider may ask you to pay the actual charge for your care at the time of your visit. After the plan-year deductible has been met, you pay **20 percent** coinsurance for most out-of-network covered services. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You will be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for in-network and out-of-network deductible and coinsurance for covered medical services.

Your out-of-pocket maximum is:

$5,000 per member (or **$10,000** per family)

Cost share amounts for prescription drugs are not included in your out-of-pocket maximum.

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 your deductible, you pay nothing for in-network or out-of-network emergency room services.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. Information concerning Utilization Review is detailed in your benefit description and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics		
Plan-year deductible	$2,000 per member/$4,000 per family for in-network and out-of-network services combined	
Plan-year out-of-pocket maximum	$5,000 per member/$10,000 per family for in-network and out-of-network services combined	
Covered Services	**Your Cost In-Network**	**Your Cost Out-of-Network**
Preventive Care Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year from age 3 through age 18	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Other Outpatient Care Emergency room visits	Nothing after deductible	Nothing after deductible
Clinic visits; physicians', podiatrists', chiropractors', and mental health or substance abuse provider office visits	Nothing after deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical, occupational, and speech therapy (up to 100 visits per calendar year*)	Nothing after deductible	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (excluding routine tests)	Nothing after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Surgery and related anesthesia	Nothing after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care) General, chronic disease hospital, mental hospital or substance abuse facility care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	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.

** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).

Your Medical Benefits (continued)

Prescription Drug Benefits	Your Cost In-Network*	Your Cost Out-of-Network
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $15 for Tier 1** $30 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $30 for Tier 1** $60 for Tier 2 $150 for Tier 3	Not covered

* Cost share waived for certain orally-administered anticancer drugs.

** Cost share waived for birth control.

Get the Most from Your Plan.

Visit us at **www.bluecrossma.com/membercentral** or call **1-800-241-0803** to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

A Fitness Program for a membership at a health club or for fitness classes This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details)	$150 per year, per individual/family
A Weight Loss Program for participation in a qualified weight loss program This weight loss program applies for fees paid to: qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details)	$150 per year, per individual/family
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-800-241-0803.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com**.

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** to sign up.

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; hearing aids for members over age 21; 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. **Please note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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