



Blue Care ElectSM Enhanced Value (PPO)

Summary of Benefits

Woods Hole Oceanographic Institution

✓ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, 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.

When You Choose Preferred Providers.

After a **\$500** copayment per admission, you have full coverage for inpatient hospital, physician, and other provider covered services. The **\$500** inpatient copayment does not apply to covered admissions in a rehabilitation hospital or skilled nursing facility. For some outpatient services, you pay a **\$25** copayment for each visit. The **\$25** copayment does not apply to preventive health services. And, there is a **\$250** copayment per admission for outpatient surgery in facilities other than an office setting.

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 for Massachusetts providers.
- Visit the BlueCard® Provider Finder website at <http://provider.bcbs.com>.
- Call the BlueCard Program at **1-800-810-BLUE (2583)**, 24 hours a day, seven days a week.

When You Choose Non-Preferred Providers.

You must pay a calendar-year deductible for most out-of-network covered services. The calendar-year deductible begins on January 1 and ends on December 31 of each year. The deductible is **\$500** for each member (or **\$1,000** per family). After you have met your deductible, you pay **20** percent co-insurance for most out-of-network covered services. When the money you pay for the co-insurance equals **\$1,000** for a member in a calendar year (or **\$2,000** per family), benefits for that member (or that family) will be provided in full for those covered services for the rest of that calendar year. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your subscriber certificate. 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 co-insurance).

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). You pay a **\$100** copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. There is no deductible for these 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 subscriber certificate 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 subscriber certificate (and riders, if any) for exact coverage details.

Domestic Partner Coverage.

Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.

Your Medical Benefits

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Calendar-year deductible	None	\$500 per member \$1,000 per family
Calendar-year co-insurance maximum	None	\$1,000 per member \$2,000 per family
Covered Services		
Preventive Care Well-child care exams, including related tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • 10 visits during the first year of life • Three visits during the second year of life • One visit per calendar year from age 2 through age 18 	Nothing	20% co-insurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing	20% co-insurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% co-insurance after deductible
Routine hearing exams, including routine tests	Nothing	20% co-insurance after deductible
Routine vision exams (one every 24 months)	Nothing	20% co-insurance after deductible
Family planning services—office visits	Nothing	20% co-insurance after deductible
Other Outpatient Care Emergency room visits	\$100 per visit (waived if admitted or for observation stay)	\$100 per visit, no deductible (waived if admitted or for observation stay)
Clinic visits; physicians', podiatrists', and chiropractors' office visits	\$25 per visit	20% co-insurance after deductible
Mental health and substance abuse treatment	\$25 per visit	20% co-insurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$25 per visit	20% co-insurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$25 per visit	20% co-insurance after deductible
Diagnostic X-rays, lab tests, and other tests	Nothing	20% co-insurance after deductible
Oxygen and equipment for its administration	Nothing	20% co-insurance after deductible
Home health care and hospice services	Nothing	20% co-insurance after deductible
Prosthetic devices	Nothing	20% co-insurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds (up to \$750 per calendar year**)	All charges beyond the calendar-year maximum	20% co-insurance after deductible and all charges beyond the calendar-year maximum
Surgery and related anesthesia <ul style="list-style-type: none"> • Office and health center services • Hospital and other day surgical facility services 	\$25 per visit \$250 per admission	20% co-insurance after deductible 20% co-insurance 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.

** No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

Your Medical Benefits (continued)

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission	20% co-insurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	\$500 per admission	20% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% co-insurance after deductible
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	\$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)	\$30 for Tier 1 \$60 for Tier 2 \$100 for Tier 3	Not covered

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 Benefit toward membership at a health club (see your subscriber certificate for details)	\$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	\$150 per year, per individual/family
Blue Care Line SM —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. The subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificates and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.