BlueCross®
BlueShield®

Blue Care Elect Deductible Plan℠

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

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.

Your Deductible.

Your deductible is calculated on a calendar year basis. Your deductible is the amount of money you pay out-of-pocket each calendar year before you can receive coverage for most benefits under this plan. Your deductible is the first **$2,000** of covered charges per member each calendar year (or **$4,000** per family). **This deductible does not apply to in-network preventive health care services or to prescription drug benefits** (see chart on opposite and back pages). This deductible applies to in-network and out-of-network services combined.

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 calendar year deductible has been met, you pay nothing for inpatient hospital, physician, and other provider covered services and some outpatient services. And, for some outpatient services, after your deductible, you pay a **$15** copayment for each covered visit. The calendar year deductible and copayment do 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** 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.

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 calendar year deductible has been met, you pay **20 percent** co-insurance 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 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).

Out-of-Pocket Maximum.

The out-of-pocket maximum applies to in-network and out-of-network covered services combined. When the money you pay for the deductible, co-insurance, and copayments that are more than $100 per visit (if any) equals **$5,000** for a member in a calendar year (or **$10,000** per family), benefits for that member (or that family) will be provided in full for those covered services, based on the allowed charge, for the rest of that calendar year. The money you pay for prescription drug benefits is not included in calculating the out-of-pocket maximum.

You will still have to pay any costs that are not included in the 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 a 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 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		
Calendar year deductible	$2,000 per member/$4,000 per family for in-network and out-of-network services combined	
Calendar 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 • One visit per calendar year from age 2 through age 18	Nothing, no deductible	20% co-insurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing, no deductible	20% co-insurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% co-insurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% co-insurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% co-insurance after deductible
Family planning services–office visits	Nothing, no deductible	20% co-insurance after deductible
Other Outpatient Care Emergency room visits	Nothing after deductible	Nothing after deductible
Clinic visits; physicians', podiatrists', and chiropractors' office visits	$15 per visit after deductible	20% co-insurance after deductible
Mental health and substance abuse treatment	$15 per visit after deductible	20% co-insurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$15 per visit after deductible	20% co-insurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$15 per visit after deductible	20% co-insurance 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% co-insurance after deductible
Home health care and hospice services	Nothing after deductible	20% co-insurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% co-insurance after deductible
Prosthetic devices	Nothing after deductible	20% co-insurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds (up to a $750 calendar-year maximum**)	Deductible and all charges beyond the calendar-year maximum	Deductible, 20% co-insurance, and all charges beyond the calendar-year maximum
Surgery and related anesthesia: • Office and health center services • Hospital and other day surgical facility services	 $15 per visit after deductible Nothing after deductible	 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)	Nothing after deductible	20% co-insurance after deductible
Mental hospital and substance abuse facility care (as many days as medically necessary)	Nothing after deductible	20% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Prescription Drug Benefits 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

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℠—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 subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate 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.

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