BlueCross® BlueShield®

Advantage Blue®

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

Summary of Benefits

Low Deductible Health Plan (LDHP)

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 Care

Advantage Blue is an exclusive provider health care plan, commonly referred to as an EPO. You receive benefits only when you use preferred providers, except for covered emergency care.

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:

$500 for a member (or $**1,000** per family)

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

When You Choose Preferred Providers.

After the plan-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 there are two levels of copayment. For the following types of providers you will pay a **$20** copayment per visit:

- Family practitioner
- General practitioner
- Internist
- Nurse midwife
- Pediatrician
- Geriatric specialist
- Nurse practitioner
- Dietitian nutritionist
- Optometrist
- Audiologist
- Podiatrist
- Multi-specialty provider group

For other covered providers, usually specialists, you will pay a **$35** copayment per visit. The copayment does not apply to preventive health services. For these services,you pay nothing.

Please note: If a preferred provider refers you for covered services to another provider (such as a lab or specialist), make sure the provider you have been referred to is also a preferred provider. If the provider you use is not a preferred provider, you pay all costs even if you are referred by a preferred provider.

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.

You are covered for emergency care only. To receive coverage, any necessary follow-up care must be received from a preferred provider.

Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for in-network deductible, copayments, 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). You pay a **$150** copayment per visit for 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 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	Your Cost
Plan-year deductible	$500 per member $1,000 per family
Plan-year out-of-pocket maximum	$5,000 per member $10,000 per family
Covered Services	
Preventive Care Well-child care exams, including related 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 age18	Nothing, no deductible
Routine adult physical exams, including related tests for members age 19 or older (one per calendar year)	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including related tests	Nothing, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Other Outpatient Care Emergency room visits	$150 per visit, no deductible (waived if admitted or for observation stay)
Office visits • When performed by a family or general practitioner, internist, nurse midwife services, pediatrician, geriatric, nurse practitioner services, dietitian nutritionist, optometrist, audiologist, podiatrist, multi-specialty provider group, or mental health or substance abuse provider • When performed by other covered providers	$20 per visit, no deductible $35 per visit, no deductible
Chiropractor services	$35 per visit, no deductible
Short-term rehabilitation therapy–physical, occupational, and speech therapy (up to 100 visits per calendar year*)	$35 per visit, no deductible
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs PET scans, and nuclear cardiac imaging tests	Nothing after deductible
Oxygen and equipment for its administration	Nothing, no deductible
Home health care and hospice services	Nothing, no deductible
Prosthetic devices	20% coinsurance after deductible
Durable medical equipment and repairs–such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Surgery and related anesthesia	Nothing after deductible
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	Nothing, no deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing 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.
*** 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.

Your Medical Benefits (continued)

Covered Services	Your Cost*
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
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 $150 for Tier 3

* 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. The benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit descriptions 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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