BlueCross® BlueShield®

SUMMARY OF BENEFITS

# Blue Care Elect Deductible Plan℠

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

## 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.

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. The calendar-year deductible begins on January 1 and ends on December 31 each year. Your deductible is **$2,000** per member (or **$4,000** per family) for 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 have full coverage for inpatient hospital, physician, and other provider covered services and certain outpatient services. The calendar-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**

## 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** 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 may 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).

## Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments, and coinsurance for covered medical services. Your out-of-pocket maximum is **$5,000** per member (or **$10,000** per family) for in-network and out-of-network services combined.

## 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 per visit 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 until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. Please see your benefit description (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**<br>Well-child care exams, including routine tests, according to age-based schedule as follows:<br>• 10 visits during the first year of life<br>• Three visits during the second year of life (age 1 to age 2)<br>• Two visits for age 2<br>• 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**<br>Emergency room visits | Nothing after deductible | Nothing after deductible |
| Clinic visits; physicians' and podiatrists' office visits | Nothing after deductible | 20% coinsurance after deductible |
| Mental health or substance abuse treatment | Nothing after deductible | 20% coinsurance after deductible |
| Chiropractors' office visits | Nothing after deductible | 20% coinsurance after deductible |
| Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*) | Nothing after deductible | 20% coinsurance after deductible |
| Speech, hearing, and language disorder treatment—speech therapy | 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 |

* 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.

| Covered Services | Your Cost In-Network | Your Cost Out-of-Network |
|---|---|---|
| **Inpatient Care (including maternity care)**<br>General or chronic disease hospital care<br>(as many days as medically necessary) | Nothing after deductible | 20% coinsurance after deductible |
| Mental hospital or substance abuse facility care<br>(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 |
| **Prescription Drug Benefits*** | | |
| At designated retail pharmacies<br>(up to a 30-day formulary supply for each prescription or refill) | $15 for Tier 1**<br>$30 for Tier 2<br>$50 for Tier 3 | Not covered |
| Through the designated mail service pharmacy<br>(up to a 90-day formulary supply for each prescription or refill) | $30 for Tier 1**<br>$60 for Tier 2<br>$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.

| | |
|---|---|
| **Wellness Participation Program**<br>**Reimbursement for a membership at a health club or for fitness classes**<br>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 calendar year per policy |
| **Reimbursement for participation in a qualified weight loss program**<br>This weight loss program applies for fees paid to: a 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 calendar year per policy |
| 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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