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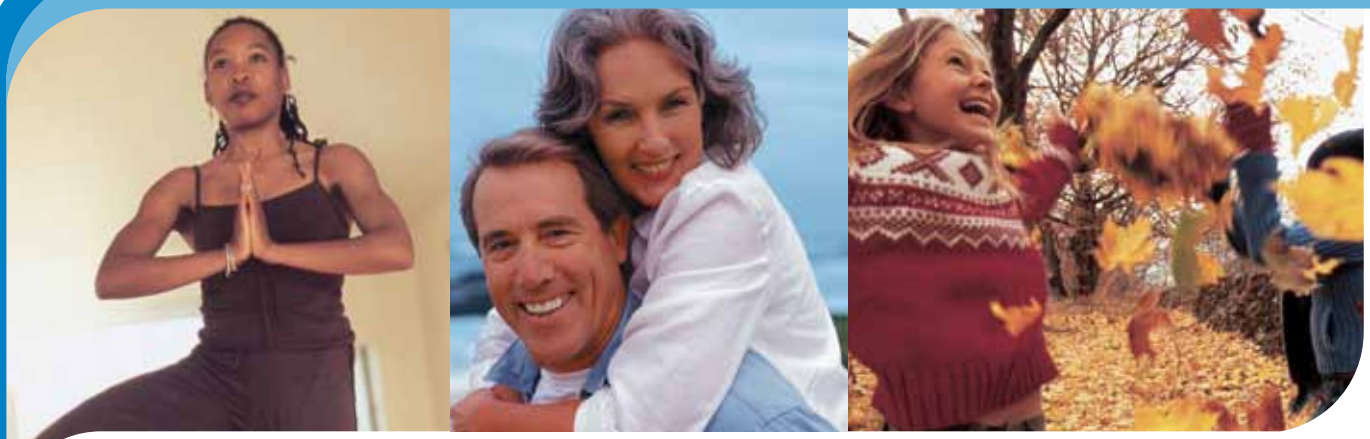

Access Blue℠ Enhanced Value

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 Care

Access.

This plan gives you the option to go directly to a specialist or any doctor in the HMO Blue® network without a referral. **No referrals are ever needed**. Just show your Blue Cross Blue Shield ID card and receive care. However, authorizations are required for some services. Please see your subscriber certificate for details.

Personal PCP Selection.

Although it's not required, it is recommended that you designate a Primary Care Provider (PCP). Having a designated PCP who knows you and your family's health history makes good health sense. Also, your out-of-pocket costs for some services will be less when you visit your designated PCP. Your provider may also work with Blue Cross Blue Shield concerning the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review is detailed in your subscriber certificate.

You can designate a PCP in two ways: consult your Provider Directory and note your PCP on the Enrollment Form, or call the Member Service number on your ID card once you are a member.

There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com;** consult the Provider Directory; or call our Physician Selection Service at **1-800-821-1388.** If you have trouble choosing a doctor, the Physician Selection Service can help. They can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Office Visit Copayments.

Your copayment for office visits to your designated PCP, or an OB-GYN physician, nurse practitioner, or nurse midwife is **$10** per visit. Your copayment for office visits to other network providers is **$30** per visit.

Out-of-Pocket Maximum for Certain Copayments.

You're protected by an out-of-pocket maximum of **$2,000** for each member in a calendar year (or **$4,000** per family). Only copayments for inpatient admissions, outpatient day surgical admissions, and emergency room visits will be applied to your out-of-pocket maximum. You will still have to pay any costs for other types of services that are not included in calculating the out-of-pocket maximum.

Emergency Care–Wherever You Are.

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 emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts.

When Outside the Service Area.

If you're traveling outside the service area and you need urgent or emergency care, go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care outside the service area must be authorized by the plan. Please see your subscriber certificate for more information.

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

Covered Services	Your Cost
Outpatient Care	
Emergency room visits	$100 per visit (waived if admitted or for observation stay)
Well-child care visits	Nothing
Routine adult physical exams, including related tests (one per calendar year)	Nothing
Routine GYN exams, including related lab test (one per calendar year)	Nothing
Routine vision exams (one every 24 months)	Nothing
Routine hearing exams	Nothing
Family planning services–office visits	Nothing
Preventive dental care for children under age 12 (one visit each six months)	Nothing
Mental health and substance abuse treatment	$10 per visit
Office visits • When performed by your designated PCP, OB-GYN physician, nurse practitioner, or nurse midwife • When performed by other network providers	 $10 per visit $30 per visit
Chiropractor services (up to 12 visits per calendar year for members age 16 or older)	$30 per visit
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*)	$30 per visit
Speech, hearing, and language disorder treatment–speech therapy	$30 per visit
Diagnostic X-rays, lab tests, and other tests	Nothing
Home health care and hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Durable medical equipment–such as wheelchairs, crutches, and hospital beds (up to $750 per calendar year**)	All charges beyond the calendar-year benefit maximum
Prosthetic devices	20% co-insurance
Surgery and related anesthesia • Office setting – When performed by your designated PCP, or OB-GYN physician – When performed by other network providers • Ambulatory surgical facility, hospital, or surgical day care unit	 $10 per visit $30 per visit $250 per admission***
Inpatient Care (including maternity care) General or chronic disease hospital care (for as many days as medically necessary)	$500 per admission***
Mental hospital or substance abuse facility care (as many days as medically necessary)	$500 per admission***
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care and 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.

*** Copayments for consecutive inpatient admissions (or day surgery followed by inpatient care) within 30 days for the same or related illness will not exceed $500.

Your Medical Benefits (continued)

Covered Services	Your Cost
Prescription Drug Benefits with BlueValue Rx℠ Formulary 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 $100 for Tier 3

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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