BlueCross® BlueShield®

Blue Care Elect Deductible Plan℠

Plan-Year Deductible: $250/$750

Summary of Benefits

City of Newburyport

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the preferred general hospitals listed in this Summary of Benefits, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital (not listed in this Summary of Benefits) for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **www.bluecrossma.com/hospitalchoice.** Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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.

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 deductibles are:

In-Network: $250 per member (or **$750** per family)
Out-of-Network: $400 per member (or **$800** per family)

The following services are not subject to the deductible: in-network preventive health services, certain in-network services with a copayment, and prescription drugs.

When You Choose Preferred Providers.

In addition to your deductible for certain services, you must pay a copayment for some services. See the charts on the opposite and back page for your cost share amounts.

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.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Berkshire Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Harrington Memorial Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

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 plan-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 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 coinsurance).

Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for in-network and out-of-network deductible, copayments, and coinsurance for covered medical services.

Your out-of-pocket maximum is:
$2,500 per member (or **$5,000** 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). After your in-network deductible, you pay a **$100** per visit copayment for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay.

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		
Plan-year deductible	$250 per member $750 per family	$400 per member $800 per family
Plan-year out-of-pocket maximum	$2,500 per member/$5,000 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 (age 1 to age 2) • Two visits for age 2 • 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 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
Hearing Benefits Routine hearing exams	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum	20% coinsurance after deductible and all charges beyond the benefit maximum
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for an observation stay)	$100 per visit after in-network deductible (copayment waived if admitted or for an observation stay)
Office visits • Family or general practitioner, geriatric specialist, internist licensed dietitian nutritionist, optometrist, nurse midwife, nurse practitioner, OB/GYN or pediatrician • Other covered providers	$20 per visit, no deductible $35 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Chiropractor services (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$15 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans and nuclear cardiac imaging tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans and nuclear cardiac imaging tests	$100 per category per service date 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	40% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing**	20% coinsurance after deductible
Surgery and related anesthesia: • Family or general practitioner, geriatric specialist, internist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician • Other covered providers • Hospital and other day surgical facility services	$20 per visit,*** no deductible $35 per visit,*** no deductible $150 per admission after deductible	20% coinsurance after deductible 20% coinsurance 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.
** 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 In-Network	Your Cost Out-of-Network
Inpatient Care (including maternity care)		
• General hospital care (as many days as medically necessary)	$300 per admission after deductible*	20% coinsurance after deductible
• In higher cost share hospitals (as many days as medically necessary)	$700 per admission after deductible*	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$200 per admission after deductible	20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% co-insurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Prescription Drug Benefits** At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1*** $25 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 $20 for Tier 1*** $50 for Tier 2 $110 for Tier 3	Not covered

* This cost share applies to mental health admissions.

** 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 **1-800-782-3675** to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

Wellness Participation Program	
Reimbursement 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 calendar year per policy
Reimbursement for participation in a qualified weight loss program 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 1-800-782-3675.

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; 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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