BlueCross® BlueShield®

SUMMARY OF BENEFITS

Network Blue New England℠ Deductible

With Hospital Choice Cost Sharing

Plan-Year Deductible: $250/$750

City of Haverhill

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 cost share (such as copayments and/or coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from any of the network general hospitals listed in this Summary of Benefits, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital (not listed in this Summary of Benefits) for which you pay the lowest 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.

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

✔ 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

Your Primary Care Provider.

When you enroll in Network Blue New England, you must choose a primary care provider (PCP) who is available to accept you and your family members and participates in our network of providers throughout the New England states. For children, you may designate a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYNs: 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. We 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.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is probably someone affiliated with your PCP's hospital or medical group. You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield concerning referrals, and 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 and services requiring referral from your PCP is detailed in your benefit description.

Your Cost Share.

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive certain inpatient services at "higher cost share hospitals." See the chart on the opposite page for your cost share amounts.

Please note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain inpatient services at these hospitals, even if your PCP 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
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Dana-Farber Cancer Institute
- Fairview 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

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

Your Deductible.

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. Your deductible is **$250** per member (or **$750** per family).

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$2,500** per member (or **$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

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). After the deductible, 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, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area.

If you're traveling outside your 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 must be arranged by your PCP. Please see your subscriber certificate for more information.

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.

Your Medical Benefits

Covered Services	Your Cost
Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Well-child care visits	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum, no deductible
Routine vision exams (one every 12 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Office visits • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	 $20 per visit, no deductible $35 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible
Mental health and substance abuse treatment	$15 per visit, no 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
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia • Office setting – When performed by your PCP, OB-GYN, nurse practitioner, or nurse midwife – When performed by other network providers • Ambulatory surgical facility, hospital, or surgical day care unit	 $20 per visit,*** no deductible $35 per visit,*** no deductible $150 per admission after deductible
Inpatient care (including maternity care) • In other general hospitals (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	 $300 per admission after deductible† $700 per admission after deductible†
Mental hospital and substance abuse facility care (as many days as medically necessary)	$200 per admission after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 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.

** 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.

† This copayment applies to mental health admissions in a general hospital.

Prescription Drug Benefits	Your Cost*
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
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

* 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.

® Registered Marks of the Blue Cross and Blue Shield Association. SM Service Marks of the Blue Cross and Blue Shield Association.
SM' Service Marks of Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield HMO Blue, Inc.
© 2015 Blue Cross and Blue Shield of Massachusetts, Inc. Printed at Blue Cross and Blue Shield of Massachusetts, Inc.

149577BS (5/15) TBD CD

BlueCross® BlueShield®