BlueCross® BlueShield®

SUMMARY OF BENEFITS

Blue Care Elect Preferred℠ (PPO)

90 With Copayment

I.U.O.E. Local 98

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 **$300** per member (or **$600** per family) for in-network and out-of-network services combined.

When You Choose Preferred Providers.

After your deductible has been met, you pay **10 percent** coinsurance for inpatient hospital, physician, and other provider covered services and some outpatient services. And, for other outpatient services you pay a **$20** copayment for each visit. After your deductible, you also pay a **$250** per admission copayment for outpatient surgery in facilities other than an office setting. **The calendar-year deductible and copayment do not apply to preventive care services. Your copayments do not count toward your deductible.**

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.

After your deductible has been met, you pay **30 percent** coinsurance for most out-of-network covered services. **However, you pay 20 percent coinsurance after your deductible for covered out-of-network outpatient services when the corresponding in-network benefit is covered in full or just a copayment.** Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your subscriber certificate. 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 services. Your medical out-of-pocket maximum is **$3,000** per member (or **$6,000** per family) for in-network and out-of-network services combined. Your calendar year out-of-pocket maximum for prescription drugs is **$1,000** per member (or **$2,000** per family).

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 **$100** copayment per visit for in-network or out-of-network 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 subscriber certificate 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 subscriber certificate (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Calendar-year deductible	$300 per member/$600 per family for in-network and out-of-network services combined	
Calendar-year out-of-pocket maximum	$3,000 per member/$6,000 per family for in-network and out-of-network services combined	
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 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
Family planning services–office visits	Nothing, no deductible	20% coinsurance after deductible
Other Outpatient Care Emergency room visits	$100 per visit, no deductible (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Clinic visits; physicians' and podiatrists' office visits	$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$20 per visit, no deductible	20% coinsurance after deductible
Chiropractors' office visits	$20 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$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, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (excluding routine tests)	10% coinsurance after deductible	30% coinsurance after deductible
Oxygen and equipment for its administration	10% coinsurance after deductible	30% coinsurance after deductible
Home health care and hospice services	10% coinsurance after deductible	30% coinsurance after deductible
Prosthetic devices	10% coinsurance after deductible	30% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	10% coinsurance after deductible**	30% coinsurance after deductible**
Surgery and related anesthesia • Office and health center services • Hospital and other day surgical facility services	$20 per visit***, no deductible $250 per admission 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 (20% coinsurance after deductible out-of-network).
*** 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.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	10% coinsurance after deductible	30% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	10% coinsurance after deductible	30% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	10% coinsurance after deductible	30% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	10% coinsurance after deductible	30% coinsurance after deductible
Prescription Drug Benefit*		
Calendar year out-of-pocket maximum	$1,000 per member $2,000 per family	Not covered
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1** $25 for Tier 2 $45 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1** $50 for Tier 2 $90 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 **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 subscriber certificate 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 subscriber certificate 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 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: routine vision exams; 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 subscriber certificate and riders.

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