BlueCross® BlueShield®

SUMMARY OF BENEFITS

Network Blue® New England Options Deductible v.5

Plan-Year Deductible: $500/$1,000

City of Worcester - New Settled

This health plan includes a tiered provider network called HMO Blue New England Options v.5. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year.
For help in finding the benefits tier of a provider, visit the online provider search tool at **bluecrossma.com/findadoctor** and search for HMO Blue New England Options v.5.

MyBlue is a personalized way to access and manage your health plan. Get secure access to key plan information, claims history, and recent medications. Download or email a copy of your digital ID card. View your spending dashboard, important updates, alerts and notifications. Register or log in at bluecrossma.com/myblue or download the app on iTunes®′ or Google Play™.

Your Care

Within the HMO Blue New England Options v.5 network, hospitals and groups of primary care providers (PCPs) are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier providers each time you get hospital or PCP care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.
- **Standard Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and are moderate cost relative to our benchmark. This benefit tier includes hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.
- **Basic Benefits Tier**—Includes Massachusetts hospitals that are high cost relative to our benchmark. Also includes primary care providers in Massachusetts who do not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pocket costs when you choose providers in the Basic Benefits Tier.

Note: Primary care providers were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Providers without sufficient data for either cost or quality are placed in the Standard Benefits Tier. Providers that do not meet benchmarks for one or both of the domains and hospitals that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your primary care provider and the facility where your provider has admitting privileges before you choose a PCP or receive care. For example, if you require hospital care and your Enhanced Benefits Tier PCP refers you to an Enhanced Benefits Tier hospital, you would pay the lowest cost sharing for both your PCP and hospital services. Or, if your Enhanced Benefits Tier PCP refers you to a Basic Benefits Tier hospital for care, you will pay the lowest copayments for PCP services, but the highest copayments for hospital services, except in an emergency.

Copayments Outside of Massachusetts and New Hampshire

For network providers outside of Massachusetts and New Hampshire, a network provider who is listed as a general practitioner, internist, family practitioner, pediatrician, obstetrician/gynecologist, nurse practitioner, rural health center, or general hospital is considered an Enhanced Benefits Tier provider. In New Hampshire, a Tier 1 provider equates to an Enhanced Tier Benefits provider and a Tier 2 provider equates to a Standard Tier Benefits provider. Other providers in our New England network carry the higher, specialist copayment.

Your Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians: visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com/findadoctor**; consult the Provider Directory; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English 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. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely 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 physician services. Your providers may also work with Blue Cross Blue Shield of Massachusetts concerning referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for some general hospital services under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$500** per member (or **$1,000** per family) for all tiers combined.

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 is **$5,000** per member (or **$10,000** per family) for all tiers 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). You pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital. Any follow-up care must be arranged by your PCP.

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 the service area and you need urgent or emergency care, you should 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. See your benefit description 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. See your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
Preventive Care Well-child care exams, including routine tests and immunizations	Nothing	Nothing	Nothing
Routine adult physical exams, including routine tests and immunizations	Nothing	Nothing	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	Nothing	Nothing
Routine hearing exams, including routine tests	Nothing	Nothing	Nothing
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum	All charges beyond the maximum	All charges beyond the maximum
Routine vision exam (one every 24 months)	Nothing	Nothing	Nothing
Family planning services–office visits	Nothing	Nothing	Nothing
Outpatient Care Emergency room visits	$150 per visit (waived if admitted or for observation stay)	$150 per visit (waived if admitted or for observation stay)	$150 per visit (waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, nurse midwife, physician assistant, or nurse practitioner (billed by PCP) • A nurse midwife, physician assistant, or nurse practitioner (not billed by PCP) designated as primary care, or a limited services clinic • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit $20 per visit $50 per visit	$30 per visit $20 per visit $50 per visit	$40 per visit $20 per visit $50 per visit
Mental health or substance use treatment	$20 per visit	$20 per visit	$20 per visit
Chiropractors' office visits	$50 per visit	$50 per visit	$50 per visit
Short-term rehabilitation therapy–physical, occupational, and speech (up to 60 visits per calendar year*)	$50 per visit	$50 per visit	$50 per visit
Diagnostic X-rays and lab tests, when performed: • In general hospitals • By other covered providers	Nothing Nothing	Nothing after deductible† Nothing	Nothing after deductible Nothing
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, when performed: • In general hospitals • By other covered providers	$100 per category per service date $100 per category per service date	$250 per category per service date after deductible† $100 per category per service date	$500 per category per service date after deductible $100 per category per service date
Home health care and hospice services	Nothing	Nothing	Nothing
Oxygen and equipment for its administration	Nothing	Nothing	Nothing
Durable medical equipment–such as wheelchairs, crutches, and hospital beds	20% coinsurance**	20% coinsurance**	20% coinsurance**
Prosthetic devices	20% coinsurance	20% coinsurance	20% coinsurance
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, nurse midwife, physician assistant, or nurse practitioner (billed by PCP) • A nurse midwife, physician assistant, or nurse practitioner (not billed by PCP) designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit*** $20 per visit*** $50 per visit***	$30 per visit*** $20 per visit*** $50 per visit***	$40 per visit*** $20 per visit*** $50 per visit***
Surgery and related anesthesia, when performed in: • A surgical day care unit • An ambulatory surgical facility	$250 per admission $250 per admission	$500 per admission after deductible $550 per admission at select hospitals† $250 per admission	$750 per admission after deductible $250 per admission
Inpatient Care (and maternity care) General hospital care (as many days as medically necessary)	$275 per admission	$750 per admission after deductible $800 per admission at select hospitals†	$1,000 per admission after deductible
Chronic disease hospital care (as many days as medically necessary)	$275 per admission	$275 per admission	$275 per admission
Mental hospital or substance use facility care (as many days as medically necessary)	$275 per admission	$275 per admission	$275 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	Nothing	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	Nothing	Nothing

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care, treatment of autism spectrum disorders, or speech therapy.
** 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.
† The select Standard Benefits Tier hospitals noted in this chart include Athol Memorial Hospital, Baystate Franklin Medical Center, Berkshire Medical Center, Falmouth Hospital, Martha's Vineyard Hospital, and Nantucket Cottage Hospital. The deductible does not apply for any covered services furnished by these hospitals.

Get the Most from Your Plan

Visit us at **bluecrossma.com** or call **1-800-932-8323** to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program **Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs** This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs. (See your benefit description for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.)	$150 per calendar year per policy
24/7 Nurse Care Line—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-800-932-8323**, or visit us online at **bluecrossma.com**.

Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at **bluecrossma.com/myblue**.

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: acupuncture visits; cosmetic surgery; custodial care; most dental care; prescription drugs for use outside of the hospital; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **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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