



Blue Care Elect DeductibleSM

Town and County of Nantucket



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

Your Choice

When You Choose Preferred Providers

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. See the charts on the opposite and back pages for your cost share.

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 a few 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 the Physician Selection Service at **1-800-821-1388**

When You Choose Non-Preferred Providers

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.

You must pay a plan-year deductible before you can receive coverage for most out-of-network benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$400** per member (or **\$800** per family).

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. 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). See the charts on the opposite and back pages for your cost share.

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 **\$2,000** per member (or **\$4,000** per family) for in-network services and **\$3,000** per member for out-of-network services. Your out-of-pocket maximum for prescription drug benefits 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 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. See the chart on the opposite page for your cost share.

Utilization Review Requirements

You must follow the requirements of Utilization Review, including Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. For detailed information about Utilization Review, see your benefit description. 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. If you do not notify Blue Cross Blue Shield of Massachusetts 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. See your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

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: <ul style="list-style-type: none"> • 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 for age 3 and older 	Nothing	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing	20% coinsurance after deductible
Routine vision exams (one every 24 months)	Nothing	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care Emergency room visits	\$25 per visit (waived if admitted or for an observation stay)	\$25 per visit, no deductible (waived if admitted or for an observation stay)
Office visits, when performed by:		
<ul style="list-style-type: none"> • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, licensed dietitian nutritionist, optometrist, nurse midwife, nurse practitioner, or physician assistant • Other covered providers 	\$20 per visit \$35 per visit	20% coinsurance after deductible 20% coinsurance after deductible
Chiropractors' office visits	\$20 per visit	20% coinsurance after deductible
Mental health or substance abuse treatment	\$20 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$20 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$100 per category of test per date of service	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Prosthetic devices	20% coinsurance	40% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance after deductible
Surgery and related anesthesia in an office, when performed by:		
<ul style="list-style-type: none"> • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, nurse practitioner, or physician assistant • Other covered providers 	\$20 per visit*** \$35 per visit***	20% coinsurance after deductible 20% coinsurance after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission	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.

** 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.

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)	\$300 per admission*	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	\$300 per admission*	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% coinsurance after deductible
Prescription Drug Benefits** At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)***	\$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)***	\$20 for Tier 1† \$50 for Tier 2 \$110 for Tier 3	Not covered

* The total inpatient copayments will not exceed \$600 per member (or \$900 per family) per plan year.

** Tier 1 generally refers to generic drugs; Tier 2 generally refers to preferred drugs; Tier 3 refers to non-preferred drugs.

*** 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 available to you, like those listed below.

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 SM —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 1-800-782-3675, or visit us online at www.bluecrossma.com.

Interested in receiving information from us 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; 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 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.