



SUMMARY OF BENEFITS



Blue Care Elect PreferredSM (PPO)

Hampshire County Group Insurance Trust

 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 charts on 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 **\$250** per member (or **\$500** 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 charts on 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 is **\$6,450** per member (or **\$12,900** per family) for in-network and out-of-network services 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 in-network or out-of-network emergency room services. See the chart on 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 related 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 | \$75 per visit (waived if admitted or for observation stay) | \$75 per visit, no deductible (waived if admitted or for observation stay) |
| Clinic visits; physicians' and podiatrists' office visits | \$20 per visit | 20% coinsurance after deductible |
| Mental health or substance abuse treatment | \$20 per visit | 20% coinsurance after deductible |
| Chiropractors' office visits | \$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, including MRIs, CT scans, PET scans and nuclear cardiac imaging tests | Nothing | 20% coinsurance after deductible |
| Oxygen and equipment for its administration | Nothing | 20% coinsurance after deductible |
| Home health care and hospice services | 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: <ul style="list-style-type: none"> • Office and health center services • Hospital and other day surgical facility services | \$20 per visit*** Nothing | 20% coinsurance after deductible 20% coinsurance after deductible |
| Inpatient care (including maternity care) General or chronic disease hospital care (as many days as medically necessary) | Nothing | 20% coinsurance after deductible |
| Mental hospital or substance abuse facility care (as many days as medically necessary) | Nothing | 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 |

* 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.

| Prescription Drug Benefits* | Your Cost In-Network** | Your Cost Out-of-Network |
|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------|
| 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 |

* 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 1-800-932-8323 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

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| Wellness Participation Program Reimbursement for a membership at a health club or for fitness classes This fitness benefit 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 benefit 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 1-800-932-8323, 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.