BlueCross® BlueShield®

SUMMARY OF BENEFITS

Blue Choice New England Plan 2

MIT Choice

An Association of Independent Blue Cross and Blue Shield Plans

Your Care

Your Primary Care Provider.

When you enroll in Blue Choice New England, you choose a primary care provider (PCP) for you and each member of your family. There are several ways to find a PCP: 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.

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. The specialist will usually be one your PCP knows, probably someone affiliated with your PCP's hospital or medical group. Your provider may also work with Blue Cross Blue Shield concerning 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 is detailed in your benefit description.

Out-of-Pocket Maximum for PCP/Plan Approved Care or MIT PCP Care

When your care is provided or arranged by your Blue Choice PCP or by your MIT Medical primary care provider (PCP), you're protected by an out-of-pocket maximum. Your out-of-pocket maximum is the most that you could pay during a calendar year for copayments and coinsurance for covered services. Your out-of-pocket maximum for PCP/Plan Approved care or MIT PCP care is **$2,500** per member or (**$5,000** per family.)

When You Choose to Receive Care on Your Own:

You also have the freedom to seek care without seeing your PCP first. When you seek care on your own from a participating provider, your out-of-pocket cost will be greater. If you require hospitalization, you, or someone on your behalf, will need to call us before you're admitted to make sure that you're covered.

You may have additional out-of-pocket expenses when you receive care without a referral from your PCP. These expenses include the following:

For self-referred services, you must pay a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible for care you seek on your own is **$500** per member (or **$1,000** per family.)

Your out-of-pocket maximum for care you seek on your own is **$2,500** per member (or **$5,000** per family.)

This out-of-pocket maximum is separate from the PCP/Plan-Approved out-of-pocket maximum. Your PCP/Plan-Approved out-of-pocket maximum does not count toward your self-referred out-of-pocket maximum.

Services by MIT Medical Primary Care Providers.

When you select an MIT Medical primary care provider to be your network primary care provider, your costs will be lower than when you select any other network primary care provider to be your network primary care provider. For example, you will pay a lower copayment for covered services furnished by your MIT Medical primary care provider or for covered services furnished by a network specialist when you have an approved referral from your MIT Medical primary care provider. You may have to pay a higher copayment for the same covered services if you have selected a network primary care provider who is not part of MIT Medical. For more information, go to **http://medweb.mit.edu/**.

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). 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. There is no deductible for these services.

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 plan's 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. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

Dependent Benefits.

This plan covers dependents until the last day of the month in which they turn age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Domestic Partner Coverage.

Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.

Your Medical Benefits

Covered Services	Your Cost for MIT Medical Primary-Care Approved Benefits	Your Cost for Network Blue New England Network PCP/ Plan Approved Benefits	Your Cost for Self-Referred/ Out-of-Network Benefits (after your deductible)
Preventive Care Well-child care visits	Nothing	Nothing	25% coinsurance
Routine adult physical exams, including related tests	Nothing	Nothing	25% coinsurance
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	Nothing	25% coinsurance
Family planning services–office visits	Nothing	Nothing	25% coinsurance
Outpatient Care Emergency room visits	$100 per visit (waived if admitted or for observation stay)	$100 per visit (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Routine vision exam (one every 12 months)	$10 per visit	$20 per visit	25% coinsurance
Routine hearing exams	$10 per visit	$20 per visit	25% coinsurance
One hearing aid or one set of binaural hearing aids (up to $1,500 per calendar year for members age 19 or under*)	All charges beyond the calendar-year maximum	All charges beyond the calendar-year maximum	All charges beyond the calendar-year maximum
Office visits	$10 per visit	$20 per visit	25% coinsurance
Acupuncture services (up to 20 visits per calendar year)	$10 per visit	$20 per visit	$20 per visit
Chiropractor office visits	$10 per visit	$20 per visit	25% coinsurance
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year**)	$10 per visit	$20 per visit	25% coinsurance
Speech, hearing, and language disorder treatment including speech therapy	$10 per visit	$20 per visit	25% coinsurance
Mental health and substance abuse treatment	$10 per visit	$20 per visit	25% coinsurance
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	Nothing	25% coinsurance
CT scans, MRIs, PET scans and nuclear cardiac imaging tests			
• Shields Health Care Group or Coolidge Corner Imaging	Nothing	Nothing	25% coinsurance
• Other covered providers	$50 per category, per date of service	$50 per category, per date of service	25% coinsurance
Oxygen and equipment for its administration	Nothing	Nothing	25% coinsurance
Home health care and hospice services	Nothing	Nothing	25% coinsurance
Prosthetic devices	Nothing	Nothing	25% coinsurance
Durable medical equipment–such as wheelchairs, crutches, and hospital beds	10% coinsurance***	10% coinsurance***	25% coinsurance
Surgery and related anesthesia			
• Office setting	Nothing	Nothing	25% coinsurance
• Ambulatory surgical facility, hospital or surgical day care unit	Nothing	Nothing	25% coinsurance

* This includes dispensing fees and acquisition costs. No benefits are provided for the replacement of lost or broken hearing aids, replacement parts, or hearing aid repairs.

** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care.

*** Cost share waived for one breast pump per birth.

Covered Services	Your Cost for MIT Medical Primary-Care Approved Benefits	Your Cost for Network Blue New England Network PCP/Plan Approved Benefits	Your Cost for Self-Referred/ Out-of-Network Benefits (after your deductible)
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	Nothing	Nothing	25% coinsurance
Mental hospital or substance abuse facility care (as many days as medically necessary)	Nothing	Nothing	25% coinsurance
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	Nothing	25% coinsurance
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	Nothing	25% coinsurance

Get the Most from Your Plan.

Visit us at **www.bluecrossma.com/membercentral** or call **1-800-882-1093** to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

A Fitness Benefit toward 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 policy per calendar year
A Weight Loss Program Benefit toward 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 policy per calendar year
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? Call 1-800-882-1093.

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 descriptions and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit descriptions and riders will govern. Some of the services not covered are: prescription drugs for use outside the hospital; cosmetic surgery; custodial care; most dental care; hearing aids for members over age 19; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit descriptions and riders.

Please 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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