BlueCross® BlueShield®

SUMMARY OF BENEFITS

Network Blue® New England

Town of Norwell HMO



MIIA MASSACHUSETTS BASED MEMBER DRIVEN

✔ 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.

An Association of Independent Blue Cross and Blue Shield Plans

Your Care

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 **www.bluecrossma.com**; consult the Provider Directory; or call the Physician Selection Service at **1-800-821-1388**.

If you have trouble choosing a doctor, the Physician Selection 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

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 services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding 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 Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for copayments and coinsurance for covered services. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your out-of-pocket maximum for medical benefits is **$2,000** per member (or **$4,000** per family). Your out-of-pocket maximum for prescription drug benefits is **$3,000** per member (or **$6,000** 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 emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

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
Preventive Care Well-child care visits	Nothing
Routine adult physical exams, including related tests	Nothing
Routine GYN exams, including related lab tests (one per plan year)	Nothing
Routine hearing exams, including routine tests	Nothing
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum
Routine vision exams (one every 12 months)	Nothing
Family planning services–office visits	Nothing
Outpatient Care Emergency room visits	$100 per visit (waived if admitted or for observation stay)
Office visits, when performed by: • Your PCP, OB/GYN physician, network nurse practitioner or nurse midwife • Other network providers	 $20 per visit $35 per visit
Chiropractors' office visits	$35 per visit
Acupuncture visits (up to 12 visits per plan year)	$35 per visit
Mental health or substance abuse treatment	$20 per visit
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per plan year*)	$35 per visit
Speech, hearing, and language disorder treatment–speech therapy	$35 per visit
Diagnostic X-rays and lab tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing
CT scans, MRIs, PET scans, and cardiac imaging tests • Hospitals • Other network providers	 $100 per category per service date** Nothing
Home health care and hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Durable medical equipment–such as wheelchairs, crutches, hospital beds	20% coinsurance***
Prosthetic devices	Nothing
Surgery and related anesthesia in an office, when performed by: • Your PCP or OB/GYN physician • Other network providers	 $20 per visit† $35 per visit†
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	$250 per admission
Mental hospital or substance abuse facility care (as many days as medically necessary)	$250 per admission
Rehabilitation hospital care (up to 60 days per plan year)	Nothing
Skilled nursing facility care (up to 100 days per plan year)	Nothing

* 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.

** When the copayments for CT scans, MRIs, PET scans, and/or nuclear cardiac imaging tests add up to the total of $375 per member in a calendar year, you pay nothing for these tests for the remainder of that calendar year.

*** 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.

Prescription Drug Benefits*	Your Cost**
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
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

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.
** Cost share may be waived for certain covered drugs and supplies.
*** Certain generic medications are available through the mail service pharmacy at $9. For more information, go to www.bluecrossma.com/mail-service-pharmacy.

Get the Most from Your Plan

Visit us at **www.bluecrossma.com** 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®—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; 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.

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see www.emiia.org/health-and-dental-insurance.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, **$2,000** member / **$4,000** family; and for prescription drug benefits, **$3,000** member / **$6,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	None
	Specialist visit	$35 / visit; $35 / chiropractor visit; $35 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per plan year
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 for hospitals; no charge for other providers	Not covered	Copayment applies per category of test / day; pre-authorization required for certain services
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications	Generic drugs	$10 / retail supply or $20 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or $50 / mail service supply	Not covered	
	Non-preferred brand drugs	$45 / retail supply or $90 / mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	Not covered	Pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$35 / visit	$35 / visit	Out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not covered	Pre-authorization required
	Physician/surgeon fees	No charge	Not covered	Pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Inpatient services	$250 / admission	Not covered	Pre-authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 / admission	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-authorization required
	Rehabilitation services	$35 / visit	Not covered	Limited to 60 visits per plan year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services
	Habilitation services	$35 / visit	Not covered	Rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Limited to 100 days per plan year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Cost share waived for one breast pump per birth
	Hospice services	No charge	Not covered	Pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	Not covered	Limited to members under age 18

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per plan year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam every 12 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Member Service number listed on your ID card or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [Yes]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	$0
■ Delivery fee copay	$0
■ Facility fee copay	$250
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,713**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$266
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$326**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$0
■ Specialist visit copay	$35
■ Primary care visit copay	$20
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,479
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,534**

Jacquie's Simple Fracture
(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	$0
■ Specialist visit copay	$35
■ Emergency room copay	$100
■ Ambulance services copay	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Jacquie would pay:

Cost Sharing	
Deductibles	$0
Copayments	$275
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Jacquie would pay is	**$275**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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MCC Compliance

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