BlueCross® BlueShield®

Preferred Blue PPO℠ $2,000 Deductible

with Hospital Choice Cost Sharing

Plan-Year Deductible: $2,000/$4,000

Summary of Benefits

Effective on anniversary dates on or after January 1, 2011

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents effective January 1, 2011, as part of the Massachusetts Health Care Reform Law.

Your Choice

Your Deductible.

Your deductible is calculated on a plan-year basis. Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact your group. Your deductible is the first **$2,000** of covered charges per member each plan year (or **$4,000** per family). **This deductible does not apply to certain in-network preventive health services and to prescription drug benefits** (see chart on opposite and back pages). For other covered services, this deductible applies to in-network and out-of-network services combined.

When You Choose Preferred Providers.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive certain services at or by "higher cost share hospitals," including inpatient admissions, outpatient day surgery, and some other hospital outpatient services. Please see the chart on opposite and back pages for cost share amounts. If you have not satisfied your deductible, your provider may ask you to pay the Blue Cross Blue Shield allowed charge for your care at the time of your visit.

Please note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to 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. It is also important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your preferred provider refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Bay State Medical Center
- Berkshire Medical Center
- Brigham and Women's Hospital
- Cape Cod Hospital
- Caritas St. Anne's Hospital
- Children's Hospital Medical Center
- Cooley Dickinson Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Harrington Memorial Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

How to Find a Preferred Provider.

There are several 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** for Massachusetts providers.
- Visit the BlueCard® Provider Finder website at **http://provider.bcbs.com.**
- Call the BlueCard Program at **1-800-810-BLUE (2583),** 24 hours a day, seven days a week.

When You Choose Non-Preferred Providers.

If you have not satisfied your deductible, your provider may ask you to pay the actual charge for your care at the time of your visit. After the plan-year deductible has been met, you pay **20 percent** co-insurance for most out-of-network covered services. In Massachusetts, payments to non-preferred providers are based on the allowed charge. Please be aware that this means you may still be responsible for any difference between the allowed charge and the provider's actual charge.

Your Out-of-Pocket Maximum.

The out-of-pocket maximum applies to in-network and out-of-network covered services combined. When the money you pay for the deductible, co-insurance, and copayments that are more than $100 (if any) equals **$5,000** for a member in a plan year (or **$10,000** per family), benefits for that member (or that family) will be provided in full for those covered services, based on the allowed charge, for the rest of that plan year. The money you pay for prescription drug benefits is not included in calculating the out-of-pocket maximum. You will still have to pay any costs that are not included in calculating the out-of-pocket maximum.

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). After your deductible, you pay a **$150** 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.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Home Health Care, and Individual Case Management. 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. Information concerning Utilization Review is detailed in your subscriber certificate and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your subscriber certificate (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services Preventive Care Outpatient Services (In-network services are not subject to the plan-year deductible.)	Your Cost In-Network (not subject to your deductible)	Your Cost Out-of-Network (after your deductible)
Plan-year deductible	None	$2,000 per member $4,000 per family
Plan-year out-of-pocket maximum	$5,000 per member/$10,000 per family for in-network and out-of-network services combined	
Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life • One visit per calendar year from age 2 through age 18	Nothing	20% co-insurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing	20% co-insurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% co-insurance after deductible
Routine hearing exams, including related tests	Nothing	20% co-insurance after deductible
Routine vision exams (one every 24 months)	Nothing	20% co-insurance after deductible
Family planning services–office visits	Nothing	20% co-insurance after deductible
Other Outpatient Care Services (In-network services are subject to the plan-year deductible.)	**Your Cost In-Network (after your deductible)**	**Your Cost Out-of-Network (after your deductible)**
Plan-year deductible	$2,000 per member/$4,000 per family for in-network and out-of-network services combined	
Plan-year out-of-pocket maximum	$5,000 per member/$10,000 per family for in-network and out-of-network services combined	
Emergency room visits	$150 per visit after deductible	$150 per visit after deductible
Allergy injections	Nothing after deductible	20% co-insurance after deductible
Clinic visits; physicians', podiatrists', and chiropractors' office visits	$15 per visit after deductible	20% co-insurance after deductible
Mental health and substance abuse treatment	$15 per visit after deductible	20% co-insurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*) • When performed in other hospitals or by other network providers • When performed at or by higher cost share hospitals	 $15 per visit after deductible $50 per visit after deductible	 20% co-insurance after deductible 20% co-insurance after deductible
Speech, hearing, and language disorder treatment–speech therapy • When performed in other hospitals or by other network providers • When performed at or by higher cost share hospitals	 $15 per visit after deductible $50 per visit after deductible	 20% co-insurance after deductible 20% co-insurance after deductible
Diagnostic X-rays and other imaging tests • When performed in other hospitals or by other network providers • When performed at or by higher cost share hospitals	 Nothing after deductible $100 per service date after deductible	 20% co-insurance after deductible 20% co-insurance after deductible
Diagnostic lab tests • When performed in other hospitals or by other network providers • When performed at or by higher cost share hospitals	 Nothing after deductible $35 per service date after deductible	 20% co-insurance after deductible 20% co-insurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests • When performed in other hospitals or by other network providers • When performed at or by higher cost share hospitals	 Nothing after deductible $450 per service date** after deductible	 20% co-insurance after deductible 20% co-insurance after deductible
Home health care and hospice services	Nothing after deductible	20% co-insurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% co-insurance after deductible
Prosthetic devices	Nothing after deductible	20% co-insurance after deductible
Durable medical equipment such as wheelchairs, crutches, hospital beds (up to a $1,500 calendar-year maximum***)	Deductible and all charges beyond the calendar-year maximum	Deductible, 20% co-insurance, and all charges beyond the calendar-year maximum
Surgery and related anesthesia in an office	$15 per visit after deductible	20% co-insurance after deductible
Ambulatory surgical facility, hospital outpatient department, or surgical day care unit • When performed in other hospitals or by other network providers • When performed in higher cost share hospitals	 Nothing after deductible $1,000 per admission after deductible	 20% co-insurance after deductible 20% co-insurance 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.

** The copayment is for each category of test for each date of service.

***No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

Your Medical Benefits (continued)

Covered Services	Your Cost In-Network (after your deductible)	Your Cost Out-of-Network (after your deductible)
Inpatient Care, including maternity care • In other general hospitals (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	Nothing after deductible $1,000 per admission after deductible*	20% co-insurance after deductible 20% co-insurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	Nothing after deductible	20% co-insurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Prescription Drug Benefits At retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $15 for Tier 1 $30 for Tier 2 $50 for Tier 3	No deductible $30 for Tier 1 $60 for Tier 2 $100 for Tier 3
Through the mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $30 for Tier 1 $60 for Tier 2 $150 for Tier 3	Not covered

* This cost share applies to mental health admissions in higher cost share hospitals.

Healthy Blue Programs

At Blue Cross Blue Shield of Massachusetts we offer you a group of programs, discounts and savings, resources, and tools to help you get the most you can from your health care plan. Call us at **1-800-262-BLUE (2583)** to receive information that outlines these special programs.

www.livinghealthybabies.com	No additional charge
A Fitness Benefit toward membership at a health club (see your subscriber certificate for details)	$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Living Healthy Vision℠—discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Safe Beginnings—discounts on home safety items	Discount varies
Blue Care Line℠ to answer your health care questions 24 hours a day—call 1-888-247-BLUE (2583)	No additional charge
Living Healthy Naturally℠—discounts on different types of complementary and alternative medicine services such as acupuncture, massage therapy, nutritional counseling, personal training, Pilates, tai chi, and yoga	Up to a 30% discount
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No additional charge

Questions? Call 1-800-262-BLUE (2583).

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 subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.

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