



Preferred Blue PPOSM \$2000 Deductible

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

Summary of Benefits

State Mental Health Change Effective July 1, 2009

✓ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents effective January 1, 2009, as part of the Massachusetts Health Care Reform Law.

Your Choice

Your Deductible.

Your deductible is calculated on a plan-year basis.

Your plan year will differ based on whether you are enrolled as a group member or as an individual. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. The 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. 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.

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. After the plan-year deductible has been met, you have full coverage for most inpatient hospital, physician, and other provider covered services.

There is no deductible for in-network preventive health services. For these services, you pay a **\$15** copayment for each covered exam.

Please 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 will be covered at the out-of-network level, even if the preferred provider refers you.

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 www.bcbs.com/healthtravel/finder.html.
- 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. 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 per visit (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 nothing for in-network or out-of-network emergency room services.

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, or for two years after the end of the calendar year in which they last qualified as a dependent under the Internal Revenue Code, whichever comes first. Additionally, this plan may cover unmarried full-time students or other unmarried dependents who do not otherwise qualify as eligible dependents. 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: <ul style="list-style-type: none"> • 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 	\$15 per visit (no cost for immunizations and routine tests)	20% co-insurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	\$15 per visit (no cost for immunizations and routine tests)	20% co-insurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	\$15 per visit (no cost for routine tests)	20% co-insurance after deductible
Routine hearing exams	\$15 per visit	20% co-insurance after deductible
Routine vision exams (one every 24 months)	\$15 per visit	20% co-insurance after deductible
Family planning services—office visits	\$15 per visit	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	Nothing after deductible	Nothing 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
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$15 per visit after deductible	20% co-insurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$15 per visit after deductible	20% co-insurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding routine tests	Nothing 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 <ul style="list-style-type: none"> • Office setting • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit 	\$15 per visit after deductible Nothing after deductible	20% co-insurance after deductible 20% co-insurance after deductible
Inpatient Care (including maternity care) General or 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

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

** 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)
Mental Health and Substance Abuse Treatment Biologically based conditions* <ul style="list-style-type: none"> • Inpatient admissions in a general or mental hospital • Outpatient visits 	Nothing after deductible \$15 per visit after deductible	20% co-insurance after deductible 20% co-insurance after deductible
Non-biologically based mental conditions <ul style="list-style-type: none"> • Inpatient admissions in a general hospital • Inpatient admissions in a mental hospital (up to 60 days per calendar year) • Outpatient visits (up to 24 visits per calendar year) 	Nothing after deductible Nothing after deductible \$15 per visit after deductible	20% co-insurance after deductible 20% co-insurance 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

* Treatment of rape-related mental or emotional disorders for victims of an assault with intent to rape, and treatment for children under age 19, are covered to the same extent as biologically based conditions.

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 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 SM —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 SM to answer your health care questions 24 hours a day—call 1-888-247-BLUE (2583)	No charge
Living Healthy Naturally SM —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 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.