



Blue Care Elect PreferredSM (PPO) 90

Summary of Benefits

State Mental Health Change Effective July 1, 2009



This health plan, on its own, does not meet 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 calendar-year basis. Your deductible is the amount of money you pay out-of-pocket each calendar year before you can receive coverage for most benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible is the first **\$250** of covered charges per member each calendar year (or **\$500** per family). This deductible applies to in-network and out-of-network services combined.

When You Choose Preferred Providers.

After your deductible has been met, you pay **10 percent** co-insurance for in-network services.

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.

After your deductible has been met, you pay **30 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.

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, 10 or 30 percent co-insurance, and copayments that are more than \$100 per visit (if any) equals **\$5,000** for a member in a calendar 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 calendar 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 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 **10 percent** co-insurance per visit 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. Information concerning Utilization Review is detailed in your subscriber certificate. 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 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

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Calendar-year deductible	\$250 per member/\$500 per family for in-network and out-of-network services combined	
Calendar-year out-of-pocket maximum	\$5,000 per member/\$10,000 per family in-network and out-of-network services combined	
Covered Services		
Outpatient Care		
Emergency room visits	10% co-insurance after deductible	10% co-insurance after deductible
Allergy injections	10% co-insurance after deductible	30% co-insurance after deductible
Clinic visits; physicians', podiatrists', and chiropractors' office visits	10% co-insurance after deductible	30% co-insurance after deductible
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 • One visit per calendar year from age 2 through age 11 • One visit every two calendar years from age 12 through age 18 	10% co-insurance after deductible	30% co-insurance after deductible
Routine adult physical exams, including related tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • Once every five calendar years from age 19 through age 29 • Once every three calendar years from age 30 through age 39 • Once every two calendar years from age 40 through age 54 • Once every calendar year age 55 and older 	10% co-insurance after deductible	30% co-insurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	10% co-insurance after deductible	30% co-insurance after deductible
Routine hearing exams	10% co-insurance after deductible	30% co-insurance after deductible
Routine vision exams (one every 24 months)	10% co-insurance after deductible	30% co-insurance after deductible
Family planning services—office visits	10% co-insurance after deductible	30% co-insurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	10% co-insurance after deductible	30% co-insurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	10% co-insurance after deductible	30% co-insurance after deductible
Diagnostic X-rays, lab tests, and other tests	10% co-insurance after deductible	30% co-insurance after deductible
Oxygen and equipment for its administration	10% co-insurance after deductible	30% co-insurance after deductible
Prosthetic devices	10% co-insurance after deductible	30% co-insurance after deductible
Home health care and hospice services	10% co-insurance after deductible	30% co-insurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds (up to \$1,500 per calendar year**)	10% co-insurance after deductible and all charges beyond the calendar-year maximum	30% co-insurance after deductible and all charges beyond the calendar-year maximum
Surgery and related anesthesia <ul style="list-style-type: none"> • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit 	10% co-insurance after deductible 10% co-insurance after deductible	30% co-insurance after deductible 30% co-insurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	10% co-insurance after deductible	30% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	10% co-insurance after deductible	30% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	10% co-insurance after deductible	30% 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	Your Cost Out-of-Network
Mental Health and Substance Abuse Treatment Biologically based conditions* <ul style="list-style-type: none"> Inpatient admissions in a general hospital, mental hospital, or substance abuse facility Outpatient visits 	10% co-insurance after deductible 10% co-insurance after deductible	30% co-insurance after deductible 30% co-insurance after deductible
Non-biologically based 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) 	10% co-insurance after deductible 10% co-insurance after deductible 10% co-insurance after deductible	30% co-insurance after deductible 30% co-insurance after deductible 10% co-insurance after deductible
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible \$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)	No deductible \$20 for Tier 1 \$50 for Tier 2 \$90 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. The subscriber certificates and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificates 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 certificates and riders.