BlueCross BlueShield

Blue Care® Elect Preferred (PPO)

90 With Copayment

Summary of Benefits

Effective on anniversary dates on or after January 1, 2008

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

An Association of Independent Blue Cross and Blue Shield Plans

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 does not apply to certain in-network outpatient services for which you pay a copayment** (see chart on opposite and back pages). 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 inpatient hospital, physician, and other provider covered services and some outpatient services.
And, for other outpatient services you pay a **$15** copayment for each visit. **The calendar-year deductible does not apply to services for which you pay a copayment. Your copayments do not count toward your deductible.**

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 preferred provider directory. If you need a copy of your provider 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. **However, you pay 20 percent co-insurance after your deductible for covered out-of-network outpatient services when the corresponding in-network benefit is a copayment, such as well-child care visits.**

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, 20 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). You pay a **$100** 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. There is no deductible for these 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 to age 26, or for two calendar years after the dependent 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 for in-network and out-of-network services combined	
Covered Services		
Outpatient Care Emergency room visits	$100 per visit, no deductible (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Allergy injections	$15 per visit, no deductible	20% co-insurance after deductible
Clinic visits; physicians', podiatrists', and chiropractors' office visits	$15 per visit, no deductible	20% co-insurance after deductible
Well-child care exams, including related 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 11 • One visit every two calendar years from age 12 through age 18	$15 per visit, no deductible (no cost for routine tests)	20% co-insurance after deductible
Routine adult physical exams, including related tests, according to age-based schedule as follows: • 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	$15 per visit, no deductible (no cost for routine tests)	20% co-insurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	$15 per visit, no deductible (no cost for routine tests)	20% co-insurance after deductible
Routine hearing exams	$15 per visit, no deductible	20% co-insurance after deductible
Routine vision exams (one every 24 months)	$15 per visit, no deductible	20% co-insurance after deductible
Family planning services–office visits	$15 per visit, no deductible	20% co-insurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$15 per visit, no deductible	20% co-insurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$15 per visit, no deductible	20% 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 and repairs	10% co-insurance after deductible	30% co-insurance after deductible
Home health care, including hospice care	10% co-insurance after deductible	30% co-insurance after deductible
Durable medical equipment and repairs–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 • 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 services are 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* Inpatient admissions in a general or mental hospital	10% co-insurance after deductible	30% co-insurance after deductible
Outpatient visits	$15 per visit, no deductible	20% co-insurance after deductible
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	10% co-insurance after deductible	30% co-insurance after deductible
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	10% co-insurance after deductible	30% co-insurance after deductible
Outpatient visits (up to 24 visits per calendar year)	$15 per visit, no deductible	20% co-insurance after deductible
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	10% co-insurance after deductible	30% co-insurance after deductible
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	10% co-insurance after deductible	30% co-insurance after deductible
Outpatient visits (up to 8 visits per calendar year**)	$15 per visit, no deductible	20% 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 and treatment for children under age 19 are covered to the same extent as biologically based conditions.

** The value of these visits is at least $500 each calendar year.

Healthy Blue Programs

At Blue Cross Blue Shield of Massachusetts we offer you Healthy Blue, 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 our *Healthy Blue* booklet, which outlines these special programs.

LIVING HEALTHY *Babies*®′	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—discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Discounts on safety helmets and 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 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 charge

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

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com**.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your 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.

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