BlueCross BlueShield

Blue Care Elect Preferred℠ (PPO)

80 With Copayment

Summary of Benefits

2010–2011 Massachusetts State Colleges Student Blue Plan

Bridgewater State College
Fitchburg State College
Framingham State College
Massachusetts College of Art and Design
Massachusetts College of Liberal Arts
Massachusetts Maritime Academy
Salem State College
Westfield State College
Worcester State College

✔ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents effective January 1, 2010, as part of the Massachusetts Health Care Reform Law.

An Association of Independent Blue Cross and Blue Shield Plans

Your Choice

When You Choose Preferred Providers.

You pay **20 percent** co-insurance for inpatient hospital, physician, and other provider covered services and some outpatient services. And, for other outpatient services you pay a **$20** copayment for each visit.

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.

You pay **40 percent** co-insurance for most out-of-network covered services. **However, you pay 20 percent co-insurance for covered out-of-network outpatient services when the corresponding in-network benefit is a copayment, such as well-child care visits.** 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.

Out-of-Pocket Maximum.

Your out-of-pocket maximum is calculated on a plan-year basis. Your plan-year begins on August 1 and ends on July 31 of each year. The out-of-pocket maximum applies to in-network and out-of-network covered services combined. When the money you pay for the 20 or 40 percent co-insurance, and copayments that are more than $100 per visit (if any) equals **$5,000** in a plan year, benefits 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 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 **$50** 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.

Explanation of Terms:

- **Co-insurance**— For some covered services under this Plan, you may have to pay a coinsurance. This means the cost that you pay for certain covered services (your "cost share amount") will be calculated as a percentage. When a coinsurance does apply to a specific covered service, Blue Cross and Blue Shield will calculate your cost share amount based on the health care provider's actual charge or the Blue Cross and Blue Shield allowed charge, whichever is less (unless otherwise required by law).
- **Out-of-Pocket Maximum**—Means your total out-of-pocket expenses during your plan year. Under your plan the out-of-pocket maximum is a total of your co-insurance and copayments that are more than $100 (if any). It does not include the following:

  —The premium paid for this health care coverage.

  —The costs that you pay that are more than the Blue Cross and Blue Shield allowed charge.

  — The costs that you pay when your coverage is reduced or denied because you did not follow the requirements of the Blue Cross and Blue Shield utilization review program

  — The costs that you pay because your health plan has provided all of the benefits it allows for that covered service.
- **Preferred Provider**— A preferred provider is a health care provider who has a written preferred provider arrangement (a "PPO payment agreement") with, or that has been designated by, Blue Cross and Blue Shield or with a local Blue Cross and/or Blue Shield Plan to provide access to covered services to members. These providers are also referred to as in-network providers.
- **Non-Preferred Provider**— Under your health care plan you also have the option to seek covered services from a covered provider who is not a preferred provider. (These health care providers are often called "non preferred providers.") In this case, you will receive the lowest benefit level under your health plan (your out of network benefits).

Your Medical Benefits

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Plan-year out-of-pocket maximum	$5,000 for in-network and out-of-network services combined	
Covered Services		
Outpatient Care Emergency room visits	$50 per visit, no deductible (waived if admitted or for observation stay)	$50 per visit, no deductible (waived if admitted or for observation stay)
Allergy injections	$20 per visit	20% co-insurance
Clinic visits; physicians', podiatrists', and chiropractors' office visits	$20 per visit	20% co-insurance
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	$20 per visit (no cost for routine tests)	20% co-insurance
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	$20 per visit (no cost for routine tests)	20% co-insurance
Routine GYN exams, including related lab tests (one per calendar year)	$20 per visit (no cost for routine tests)	20% co-insurance
Routine hearing exams	$20 per visit (no cost for routine tests)	20% co-insurance
Routine vision exams (one every 24 months)	$20 per visit	20% co-insurance
Family planning services–office visits	$20 per visit	20% co-insurance
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$20 per visit	20% co-insurance
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit	20% co-insurance
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests and routine tests	20% co-insurance	40% co-insurance
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category, per date of service	40% co-insurance
Oxygen and equipment for its administration	20% co-insurance	40% co-insurance
Prosthetic devices	20% co-insurance	40% co-insurance
Home health care and hospice services	20% co-insurance	40% co-insurance
Durable medical equipment–such as wheelchairs, crutches, hospital beds (up to $1,500 per calendar year**)	20% co-insurance and all charges beyond the calendar-year maximum	40% co-insurance and all charges beyond the calendar-year maximum
Surgery and related anesthesia • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	20% co-insurance 20% co-insurance	40% co-insurance 40% co-insurance
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	20% co-insurance	40% co-insurance
Rehabilitation hospital care (up to 60 days per calendar year)	20% co-insurance	40% co-insurance
Skilled nursing facility care (up to 100 days per calendar year)	20% co-insurance	40% co-insurance

* 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* • Inpatient admissions in a general hospital, mental hospital, or substance abuse facility • Outpatient visits	 20% co-insurance $20 per visit	 40% co-insurance 20% co-insurance
Non-biologically based mental conditions • 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)	 20% co-insurance 20% co-insurance $20 per visit	 40% co-insurance 40% co-insurance 20% co-insurance
Prescription Drug Benefits At designated 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 $15 for Tier 1 $30 for Tier 2 $50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $15 for Tier 1 $30 for Tier 2 $50 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 **1-888-753-6615** 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
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year
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 1-888-753-6615.

For any questions regarding your eligibility, please refer to the University Health Plans website at **www.universityhealthplans.com**.

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 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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