BlueCross® BlueShield®

Blue Care Elect Preferred℠ (PPO)

80 With Copayment

Summary of Benefits

2012-2013 Massachusetts State Universities Student Blue Plan

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

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

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 **$25** copayment for each visit. The copayment does not apply to preventive care 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, in most situations, 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 **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.

You must pay a plan-year deductible for most out-of-network services. The plan-year deductible begins on August 1 and ends on July 31 each year. The deductible is **$200** per member each plan year. After your deductible you pay **40 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 covered in full or requires only a copayment.**

Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your subscriber certificate. You will be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your co-insurance).

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, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, 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 deductible, 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 deductible	None	$200 per member
Plan-year out-of-pocket maximum	$5,000 per member for in-network and out-of-network services combined	
Covered Services		
Preventive Care 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 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 routine 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 Emergency room visits	$50 per visit (waived if admitted or for observation stay)	$50 per visit, no deductible (waived if admitted or for observation stay)
Clinic visits; physicians', podiatrists', and chiropractors' office visits	$25 per visit	20% co-insurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$25 per visit	20% co-insurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$25 per visit	20% co-insurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding MRIs, CT scans, PET scans, and nuclear cardiac imaging tests	20% co-insurance	40% co-insurance after deductible
MRIs, CT scans, PET scans, and nuclear cardiac imaging tests	$100 per category per date of service	20% co-insurance after deductible
Oxygen and equipment for its administration	20% co-insurance	40% co-insurance after deductible
Home health care and hospice services	20% co-insurance	40% co-insurance after deductible
Prosthetic devices	20% co-insurance	40% co-insurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds (up to a $1,500 calendar-year maximum**)	20% co-insurance and all charges beyond the calendar-year benefit maximum	40% co-insurance after deductible and all charges beyond the calendar-year benefit maximum
Surgery and related anesthesia: • Office and health center services • Hospital and other day surgical facility services	 $25 per visit 20% co-insurance	 20% co-insurance after deductible 40% co-insurance after deductible
Inpatient care (including maternity care) General or chronic disease hospital (as many days as medically necessary)	20% co-insurance	40% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	20% co-insurance	40% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	20% co-insurance	40% 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.

** 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	20% co-insurance	40% co-insurance after deductible
• Outpatient visits	$25 per visit	20% co-insurance after deductible
Non-biologically based mental conditions		
• Inpatient admissions in a general hospital	20% co-insurance	40% co-insurance after deductible
• Inpatient admissions in a mental hospital (up to 60 days per calendar year)	20% co-insurance	40% co-insurance after deductible
• Outpatient visits (up to 24 visits per calendar year)	$25 per visit	20% co-insurance after deductible
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$15 for Tier 1 $30 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$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.

Get the Most from Your Plan.

Visit us at **www.bluecrossma.com/membercentral** or call **1-888-753-6615** to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

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
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call **1-888-247-BLUE (2583)**	No additional charge

Questions? Call 1-888-753-6615.

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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