Blue Care® Elect Preferred (PPO)

Summary of Benefits

2008-2009 University of Massachusetts Lowell Student Blue Plan

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.
Your Choice

When You Choose Preferred Providers.
You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your “in-network” benefits. You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your “out-of-network” benefits.

Generally, you have full coverage for most hospital, physician, and other provider covered services. And, for some 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 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.
You must pay a calendar-year deductible for most out-of-network covered services. The calendar-year deductible begins on January 1 and ends on December 31 each year. The deductible is $250 for each member (or $500 per family). After you have met your deductible, you pay 20 percent co-insurance for most out-of-network covered services. When the money you pay for the 20 percent co-insurance equals $1,000 for a member in a calendar year (or $2,000 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.

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.

Domestic Partner Coverage.
Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.
## Your Medical Benefits

<table>
<thead>
<tr>
<th>Plan Specifics</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network (after your deductible)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar-year deductible</strong></td>
<td>None</td>
<td>$250 per member $500 per family</td>
</tr>
<tr>
<td><strong>Calendar-year co-insurance maximum</strong></td>
<td>None</td>
<td>$1,000 per member $2,000 per family</td>
</tr>
</tbody>
</table>

### Covered Services

#### Outpatient Care

**Emergency room visits**
- $100 per visit (waived if admitted or for observation stay)
- $100 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 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
- $20 per visit (no cost for routine tests)
- 20% co-insurance

**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
- $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
- 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**
- Nothing
- 20% co-insurance

**Oxygen and equipment for its administration**
- Nothing
- 20% co-insurance

**Prosthetic devices and repairs**
- Nothing
- 20% co-insurance

**Home health care, including hospice services**
- Nothing
- 20% co-insurance

**Durable medical equipment and repairs–such as wheelchairs, crutches, hospital beds (up to $1,500 per calendar year**)**
- All charges beyond the calendar-year maximum
- 20% co-insurance and all charges beyond the calendar-year maximum

### Inpatient Care (including maternity care)

**Surgery and related anesthesia**
- Office setting
- Ambulatory surgical facility, hospital, or surgical day care unit
- $20 per visit
- Nothing
- 20% co-insurance
- 20% co-insurance

**General or chronic disease hospital care (as many days as medically necessary)**
- Nothing
- 20% co-insurance

**Rehabilitation hospital care (up to 60 days per calendar year)**
- Nothing
- 20% co-insurance

**Skilled nursing facility care (up to 100 days per calendar year)**
- Nothing
- 20% co-insurance

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* 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)

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network (after your deductible)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health and Substance Abuse Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biologically based conditions*</td>
<td>Nothing</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Inpatient admissions in a general or mental hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>$20 per visit</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Non-biologically based mental conditions (includes drug addiction and alcoholism)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient admissions in a general hospital</td>
<td>Nothing</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)</td>
<td>Nothing</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Outpatient visits (up to 24 visits per calendar year)</td>
<td>$20 per visit</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Alcoholism treatment (in addition to non-biologically based mental conditions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient admissions in a general hospital</td>
<td>Nothing</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)</td>
<td>Nothing</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Outpatient visits (up to 8 visits per calendar year**)</td>
<td>$20 per visit</td>
<td>20% co-insurance</td>
</tr>
</tbody>
</table>

| **Prescription Drug Benefits**                                                   |                      |                                                  |
| At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill) | $10 for Tier 1 | $25 for Tier 2 | $45 for Tier 3 |
| Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill) | $10 for Tier 1 | $25 for Tier 2 | $45 for Tier 3 |

* Treatment for 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 in 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 1-800-241-0803 to receive our Healthy Blue booklet, which outlines these special programs.

**Living Healthy Babies**
A Fitness Benefit toward membership at a health club (see your subscriber certificate for details) No charge
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 1-800-241-0803.
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. 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.