BlueCross® BlueShield®

Blue Care Elect Preferred℠ (PPO)

90 With Copayment

Summary of Benefits

2012-2013 Wheelock College Student Blue Plan

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.

An Association of Independent Blue Cross and Blue Shield Plans

Your Choice

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.

When You Choose Preferred Providers.

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. You also pay a **$250** per admission copayment for outpatient surgery in facilities other than an office setting.

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 pay **30 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 covered in full or just 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 co-insurance).

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 co-insurance and copayments that are more than **$100** per visit (if any) equals **$5,000** for a member in a plan 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 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 **$150** 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.

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. 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
Plan-year deductible	None	None
Plan-year out-of-pocket maximum	$5,000 per member/$10,000 per family for in-network and out-of-network services combined	
Covered Services		
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
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing	20% co-insurance
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% co-insurance
Routine PSA test for members age 40 or older (one per calendar year)	Nothing	20% co-insurance
Routine hearing exams, including routine tests	Nothing	20% co-insurance
Routine vision exams (one every 24 months)	Nothing	20% co-insurance
Family planning services—office visits	Nothing	20% co-insurance
Other Outpatient Care Emergency room visits	$150 per visit (waived if admitted or for observation stay)	$150 per visit (waived if admitted or for observation stay)
Clinic visits; physicians', podiatrists', and chiropractors' office visits	$15 per visit	20% co-insurance
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$15 per visit	20% co-insurance
Speech, hearing, and language disorder treatment—speech therapy	$15 per visit	20% co-insurance
Diagnostic X-rays, lab tests, and other tests, including MRIs, CT scans, PET scans and nuclear cardiac imaging tests	Nothing	20% co-insurance
Oxygen and equipment for its administration	10% co-insurance	30% co-insurance
Home health care and hospice services	10% co-insurance	30% co-insurance
Prosthetic devices	10% co-insurance	30% co-insurance
Durable medical equipment—such as wheelchairs, crutches, hospital beds	10% co-insurance	30% co-insurance
Surgery and related anesthesia: • Office and health center services • Hospital and other day surgical facility services	 $15 per visit $250 per admission	 20% co-insurance 20% co-insurance
Inpatient care (including maternity care) General or chronic disease hospital (as many days as medically necessary)	10% co-insurance	30% co-insurance
Rehabilitation hospital care (up to 60 days per calendar year)	10% co-insurance	30% co-insurance
Skilled nursing facility care (up to 100 days per calendar year)	10% co-insurance	30% co-insurance

* 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.

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	 10% co-insurance $15 per visit	 30% 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)	 10% co-insurance 10% co-insurance $15 per visit	 30% co-insurance 30% co-insurance 20% co-insurance
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	 Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$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 a rape or 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[SM]—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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