BlueCross BlueShield

Blue Care® Elect Preferred (PPO)

Summary of Benefits

2007-2008 University of Massachusetts Boston Student Health Insurance Plan

Your Choice

When You Choose Preferred Providers.

You receive the highest level of benefits under your health care plan when you choose preferred providers. These are called your "in-network" benefits. You can also choose 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 preferred hospital, physician, and other provider covered services. And, for some outpatient services, you pay a **$10** copayment for each visit.

Please note: If a preferred provider refers you for covered services to another provider (such as a lab or specialist), make sure the provider you have been referred to is also a preferred provider. If the provider you use is not a preferred provider, your out-of-pocket costs will be higher, even if you are referred by a preferred provider.

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 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** for all family members covered under the same membership). After you have met your deductible, you pay **20** percent co-insurance for most out-of-network covered services. When the money paid for the **20** percent co-insurance equals **$1,000** for a member in a calendar year (or **$2,000** for all family members covered under the same membership), benefits for that member (or that family) will be provided in full, based on the allowed charge, for the rest of that calendar year. Refer to the subscriber certificate and riders for a definition of allowed charge and how the deductible and co-insurance are calculated.

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 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. The out-of-network deductible does not apply.

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 is no longer claimed on the subscriber's or spouse's federal tax return, 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 (after your deductible)
Calendar-year deductible	None	$250 per member $500 per family
Calendar-year co-insurance maximum	None	$1,000 per member $2,000 per family
Covered Services		
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), no deductible
Clinic visits; physicians', podiatrists', and chiropractors' office visits	$10 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	$10 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	$10 per visit (no cost for routine tests)	20% co-insurance
Routine GYN exam, including related lab tests (one per calendar year)	$10 per visit (no cost for routine tests)	20% co-insurance
Routine hearing exam	$10 per visit	20% co-insurance
Routine vision exam (one every 24 months)	$10 per visit	20% co-insurance
Routine PSA test for a member age 40 and older (one per calendar year)	Nothing	20% co-insurance
Allergy injections	$10 per visit	20% co-insurance
Family planning services–office visits	$10 per visit	20% co-insurance
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$10 per visit	20% co-insurance
Speech, hearing, and language disorder treatment–speech therapy	$10 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
Surgery and related anesthesia • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	 $10 per visit Nothing	 20% co-insurance 20% co-insurance
Inpatient Care (including maternity care) 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

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care, or to diagnose or treat speech, hearing, and language 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 (after your deductible)
Mental Health and Substance Abuse Treatment Biologically based conditions* Inpatient admissions in a general or mental hospital	Nothing	20% co-insurance
Outpatient visits	$10 per visit	20% co-insurance
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	Nothing	20% co-insurance
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing	20% co-insurance
Outpatient visits (up to 24 visits per calendar year)	$10 per visit	20% co-insurance
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	Nothing	20% co-insurance
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing	20% co-insurance
Outpatient visits (up to 8 visits per calendar year**)	$10 per visit	20% co-insurance
Prescription Drug Benefit At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1 $20 for Tier 2 $35 for Tier 3	
Through the mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$10 for Tier 1 $20 for Tier 2 $35 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*®´	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 1-800-241-0803.

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 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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