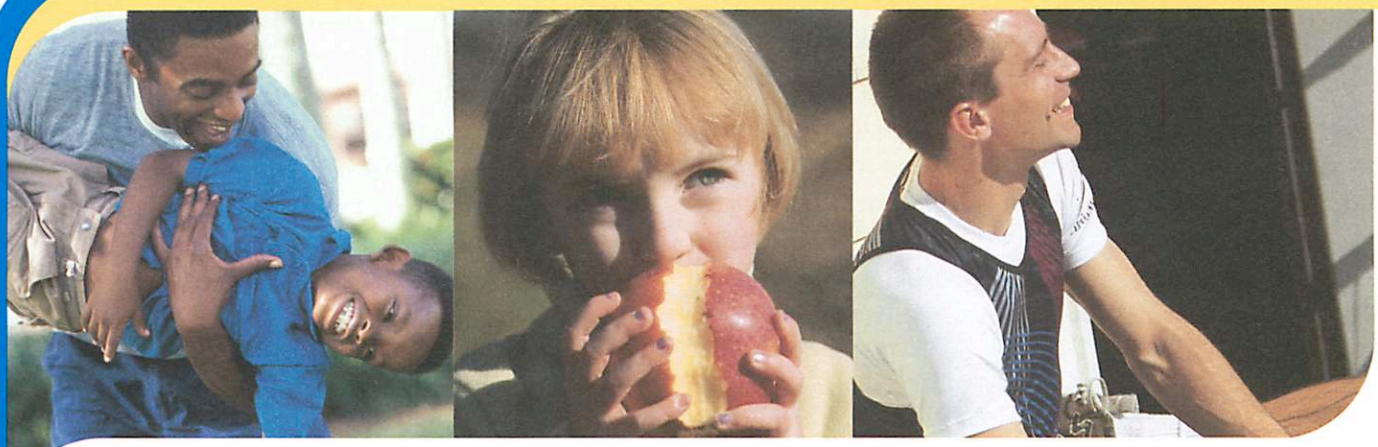
BlueCross® BlueShield®



Blue Care Elect Preferred℠ (PPO)

Summary of Benefits

MIIA Massachusetts based Member driven

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents effective January 1, 2011, 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 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 **$15** copayment for each covered visit. The **$15** 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 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 calendar-year deductible for most out-of-network covered services. The calendar-year deductible begins on January 1 and ends on December 31 of 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 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 **$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. 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. 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 benefit description 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 benefit description (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		
Preventive Health 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 hearing exams, including routine tests	Nothing	20% co-insurance
Routine vision exams (one per calendar year)	Nothing	20% co-insurance
Family planning services–office visits	Nothing	20% co-insurance
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)
Allergy injections	$15 per visit	20% co-insurance
Clinic visits; physicians', podiatrists', and chiropractors' office visits	$15 per visit	20% co-insurance
Mental health and substance abuse treatment	$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 tests, lab tests, and other tests	Nothing	20% co-insurance
Oxygen and equipment for its administration	Nothing	20% co-insurance
Prosthetic devices	Nothing	20% co-insurance
Home health care and 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	 $15 per visit Nothing	 20% co-insurance 20% 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.

** 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)
Inpatient care (including maternity care) General or chronic disease hospital (as many days as medically necessary)	Nothing	20% co-insurance
Mental hospital and substance abuse facility 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
Prescription Drug Benefits 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	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1 $40 for Tier 2 $70 for Tier 3	Not covered

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 **1-800-782-3675** to receive information that outlines these special programs.

www.livinghealthybabies.com	No additional charge
A Fitness Benefit toward membership at a health club (see your benefit description 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
Safe Beginnings—discounts on 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 1-800-782-3675.

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 benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description 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 benefit description and riders. Please Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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