



# Blue Care Elect Preferred<sup>SM</sup> (PPO)

## Summary of Benefits

Effective July 1, 2012

Scantic Valley Trust

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

# 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.

After a **\$500** per admission copayment, you have full coverage for inpatient hospital, physician, and other provider covered services. The **\$500** inpatient copayment does not apply to covered admissions in a skilled nursing facility or rehabilitation hospital. And, there is a **\$150** per admission copayment for outpatient surgery in facilities other than an office setting. For covered outpatient services there are two levels of copayment. For the following types of providers you will pay a **\$20** copayment per visit:

- Family practitioner
- General practitioner
- Geriatric specialist
- Internist
- Multispecialty provider group
- Nurse midwife
- Nurse practitioner
- OB/GYN physician
- Pediatrician

The **\$20** copayment does not apply to preventive care services. For other covered providers, usually specialists, you will pay a **\$35** copayment per visit.

You’re protected by a plan-year out-of-pocket maximum. Your plan year begins on July 1 and ends on June 30 each year. When the money you pay for the co-insurance and copayments equals **\$2,000** for a member in a plan year (or **\$4,000** 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.

**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

## 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](http://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 covered services. Your plan-year deductible begins on July 1 and ends on June 30 of each year. The deductible is **\$400** for each member (or **\$800** per family).

After you have met your deductible, you pay **20 percent** co-insurance for most out-of-network covered services. Payments for out-of-network benefits are based on the the provider’s actual charge. You will be responsible for your deductible, coinsurance and any services that are not covered.

When the money you have paid for the deductible, co-insurance, and copayments equals **\$3,000** for a member in a plan year, benefits for that member 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 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 **\$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, 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 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
<b>Plan-year deductible</b>	None	\$400 per member \$800 per family
<b>Plan-year out-of-pocket maximum</b>	\$2,000 per member \$4,000 per family	\$3,000 per member
<b>Covered Services</b>		
<b>Preventive Care</b> Well-child care exams, including related tests, according to age-based schedule as follows: <ul style="list-style-type: none"> <li>• 10 visits during the first year of life</li> <li>• Three visits during the second year of life</li> <li>• One visit per calendar year from age 2 through age 18</li> </ul>	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 12 months)	Nothing	20% co-insurance after deductible
Family planning services—office visits	Nothing	20% co-insurance after deductible
<b>Other Outpatient Care</b> 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)
Office visits <ul style="list-style-type: none"> <li>• Family or general practitioner, geriatric specialist, internist, licensed dietitian nutritionist, multi-specialty provider group, optometrist, nurse midwife, nurse practitioner, OB/GYN physician, or pediatrician</li> <li>• Other covered providers</li> </ul>	\$20 per visit  \$35 per visit	20% co-insurance after deductible  20% co-insurance after deductible
Chiropractors' office visits	\$20 per visit	20% co-insurance after deductible
Mental health and substance abuse treatment	\$20 per visit	20% co-insurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$20 per visit	20% co-insurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit	20% co-insurance after deductible
Diagnostic X-rays tests, lab tests, and other tests, excluding MRIs, CT scans, PET scans and nuclear cardiac imaging tests	Nothing	20% 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	Nothing	20% co-insurance after deductible
Home health care and hospice services	Nothing	20% co-insurance after deductible
Prosthetic devices	20% co-insurance	40% co-insurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% co-insurance	40% co-insurance after deductible
Surgery and related anesthesia in an office or health center setting <ul style="list-style-type: none"> <li>• Family or general practitioner, geriatric specialist, internist, multi-specialty provider group, nurse midwife, nurse practitioner, OB/GYN physician, or pediatrician</li> <li>• Other covered providers</li> </ul>	\$20 per visit  \$35 per visit	20% co-insurance after deductible  20% co-insurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission	20% 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.

# Your Medical Benefits (continued)

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
<b>Inpatient care (including maternity care)</b> General or chronic disease hospital (as many days as medically necessary)	\$500 per admission	20% co-insurance after deductible
Mental hospital and substance abuse facility care (as many days as medically necessary)	\$500 per admission	20% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% co-insurance after deductible
<b>Prescription Drug Benefits</b> At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	\$10 for Tier 1 \$25 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)	\$20 for Tier 1 \$50 for Tier 2 \$110 for Tier 3	Not covered

## Get the Most from Your Plan.

Visit us at [www.bluecrossma.com/membercentral](http://www.bluecrossma.com/membercentral) or call 1-800-932-8323 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 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
Blue Care Line <sup>SM</sup> —A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

## Questions? Call 1-800-932-8323.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at [www.bluecrossma.com](http://www.bluecrossma.com).

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?

Go to [www.bluecrossma.com/email](http://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.