

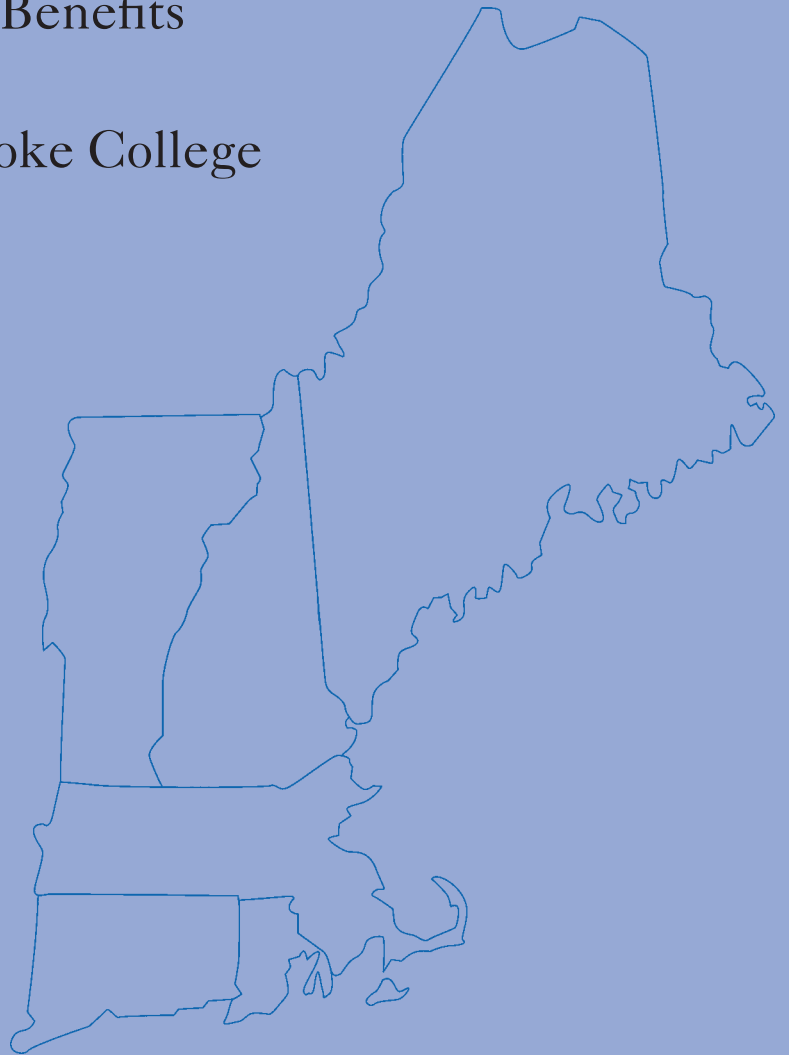


# Blue Choice<sup>®</sup> New England

\$15/\$25 Office Visit and  
\$75 Emergency Room Copayment Option

Summary of Benefits

Mount Holyoke College



BlueCross  
BlueShield

An Association of Independent Blue Cross and Blue Shield Plans

## Your Choice

You decide how you want to balance choice and value, every time you need care. Blue Choice New England is a point-of-service plan, or POS, which means your level of coverage is determined at the point you receive medical care. You make the most of your coverage and pay less out of your own pocket when your care is provided or coordinated by your network primary care physician (PCP). On the other hand, you can access care on your own through any participating provider and receive coverage, but you'll have to pay a deductible and co-insurance if you do.

### Your Primary Care Physician.

When you join Blue Choice New England, you choose a primary care physician (PCP) for you and each member of your family. There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at [www.bluecrossma.com](http://www.bluecrossma.com); consult the *HMO Blue New England Directory of Providers*; or call our Physician Selection Service at 1-800-821-1388. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

### Your PCP Coordinates All of Your Health Care Needs.

Your PCP is the first person you call when you need medical care. If your PCP determines that you need to see a specialist, you'll be referred to the appropriate specialist affiliated with your PCP's network, which is also the network where you'll receive inpatient care if needed. Your physician may also work with Blue Cross Blue Shield concerning the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review is detailed in your subscriber certificates. As long as your care is provided or arranged by your Blue Choice New England PCP, your out-of-pocket expenses will be minimal.

You also have the freedom to seek care without seeing your PCP first. When you seek care on your own from a participating provider, your out-of-pocket cost will be greater. If you require hospitalization, you, or someone on your behalf, will need to call Member Service before you're admitted to make sure that you're covered.

## When You Choose to Receive Care on Your Own:

- For some services, you must meet a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. You pay a deductible of **\$250** per member each calendar year (**\$500** for all family members covered under the same membership). After your deductible, you pay **20%** co-insurance for most covered services.
- When the money you've paid for your 20% co-insurance equals **\$500** for a member in a calendar year (**\$1,000** for all family members covered under the same membership), then your benefits (or your family's benefits) are provided in full, based on the allowed charge, up to any benefit maximums for the rest of that calendar year.
- For services not approved for PCP/Plan Approved benefits, Blue Choice New England provides up to **\$2,000,000** in benefits in a lifetime for each member.

### Urgent Care.

If you need urgent medical care, call your PCP to arrange where you'll receive treatment. Examples of urgent care are sprains, earaches, and high fever.

### Urgent Care Away from Home.

If you're traveling outside of the plan service area (the state in which your PCP is located) and you need urgent care, go to the nearest medical facility. You, or someone on your behalf, must call your PCP within 48 hours (no call is needed if you go to an emergency room). To receive the highest level of coverage, any follow-up care must be arranged by your PCP.

### Emergency Care—Wherever You Are.

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). There is a **\$75** copayment for emergency room services, which is waived if you're admitted to the hospital. To receive the highest level of coverage, any follow-up care must be arranged by your PCP.

### 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.

### Domestic Partner Coverage.

Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.

# Your Medical Benefits

Covered Services	Your Cost For PCP/Plan Approved Benefits	Your Cost For Self-Referred Major Medical Benefits (after your deductible)
<b>Outpatient Care</b>		
<b>Office visits</b>		20% co-insurance
When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife	\$15 per visit	
When performed by all other network providers	\$25 per visit	
Well-child care	\$15 per visit	20% co-insurance
Routine checkups (including one GYN exam per calendar year)	\$15 per visit	20% co-insurance
Maternity care	Nothing	20% co-insurance
Diagnostic X-rays, lab tests, and other tests	Nothing	20% co-insurance
<b>Hearing exams</b>		20% co-insurance
When performed by your PCP or network nurse practitioner	\$15 per visit	
When performed by other network providers	\$25 per visit	
Vision exams (one per calendar year)	\$25 per visit	20% co-insurance
Emergency room visits	\$75 per visit (waived for observation stay or if admitted)	20% co-insurance*
Allergy injections only	Nothing	20% co-insurance
Family planning	\$15 per visit	20% co-insurance
Infertility services	\$15 per visit Nothing for surgical services	20% co-insurance
Short-term rehabilitation therapy (physical and occupational): Covered up to 60 visits per calendar year***	\$25 per visit	20% co-insurance
Speech, hearing, and language disorder treatment (speech therapy)	\$15 per visit	20% co-insurance
Home health care and hospice care	Nothing	20% co-insurance
Chiropractor services	\$25 per visit	20% co-insurance
Durable medical equipment (such as wheelchairs, crutches, hospital beds): Covered up to a maximum of \$1,500 per calendar year****	All charges beyond the calendar-year benefit maximum	20% co-insurance and all charges beyond the calendar-year benefit maximum
Oxygen and equipment for its administration	Nothing	20% co-insurance
Prosthetic devices	Nothing	20% co-insurance
<b>Inpatient Care (including maternity care)</b>		
Hospital care (as many days as medically necessary)	\$250 per admission†	20% co-insurance
Care in a skilled nursing facility (up to 100 days per calendar year)	Nothing	20% co-insurance
Care in a rehabilitation hospital (up to 60 days per calendar year)	Nothing	20% co-insurance
<b>Mental Health and Substance Abuse Treatment</b>		
<b>Biologically based conditions††</b>		
Inpatient admissions in a general hospital or mental hospital	\$250 per admission†	20% co-insurance
Outpatient visits	\$15 per visit	20% co-insurance
<b>Non-biologically based mental conditions (includes drug addiction and alcoholism)</b>		
Inpatient admissions in a general hospital	\$250 per admission†	20% co-insurance
Inpatient admissions in a mental hospital or substance abuse treatment facility	\$250 per admission† (up to 60 days per calendar year)	20% co-insurance (up to 60 days per calendar year)
Outpatient visits	\$15 per visit (up to 24 visits per calendar year)	20% co-insurance (up to 24 visits per calendar year)
<b>Alcoholism treatment (in addition to non-biologically based mental conditions)</b>		
Inpatient admissions in a general hospital	\$250 per admission†	20% co-insurance
Inpatient admissions in a substance abuse treatment facility	\$250 per admission† (up to 30 days per calendar year)	20% co-insurance (up to 30 days per calendar year)
Outpatient visits	\$15 per visit (up to 8 visits per calendar year)†††	20% co-insurance (up to 8 visits per calendar year)†††

\* If this visit is for emergency care, you will only have to pay a \$75 copayment per visit.

\*\* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or to diagnose and 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 copayment for an inpatient admission followed by outpatient day surgery or additional inpatient care (or for outpatient day surgery followed by inpatient care) within 30 days for the same or related illness will not be more than \$500.

†† 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.

## Your Medical Benefits (continued)

Covered Services	Your Cost
<b>Prescription Drug Benefit</b> At designated retail pharmacies (up to a 30-day formulary supply for each prescription/refill or supply)	\$10 for Tier 1 \$20 for Tier 2 \$35 for Tier 3
Through mail service drug program (up to a 90-day formulary supply for each prescription/refill or supply)	\$20 for Tier 1 \$40 for Tier 2 \$70 for Tier 3

## 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 **1-800-486-1136** to receive our *Healthy Blue* booklet, which outlines these special programs.

LIVING HEALTHY <i>Babies</i> <sup>®</sup>	No charge
A Fitness Benefit toward membership at a health club (see your subscriber certificates 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 <sup>®</sup> Vision—discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Discounts on safety helmets and home safety items	Discount varies
Living Healthy <sup>®</sup> 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
Blue Care <sup>®</sup> Line to answer your health care questions 24 hours a day—call <b>1-888-247-BLUE (2583)</b>	No charge
Visit <a href="http://www.AHealthyMe.com">www.AHealthyMe.com</a> for an around-the-clock healthy approach to fitness, family, and fun	No charge

## Questions? Call 1-800-486-1136.

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

**Limitations and Exclusions.** These pages highlight some of the benefits of your Blue Choice New England plan. Your subscriber certificates and riders define the terms and conditions of your plan. Should any questions arise, the subscriber certificates and riders will govern. Some of the services we don't cover are: custodial care; cosmetic surgery; most dental care; hearing aids; or any services covered by workers' compensation. For a complete list of limitations and exclusions, please refer to your subscriber certificates.