




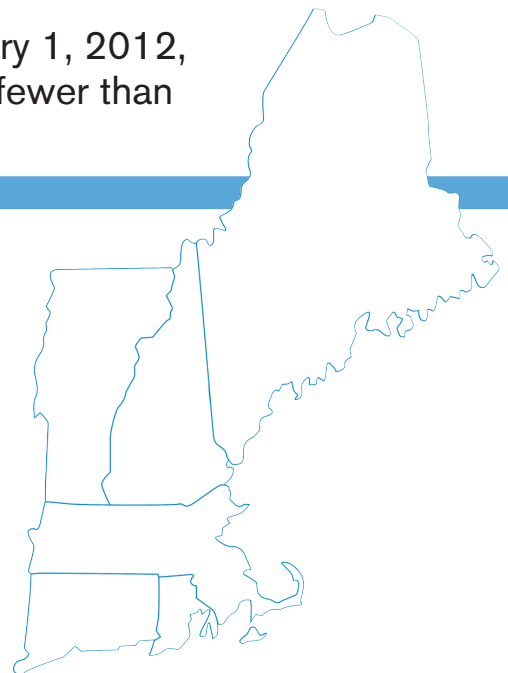
HMO Blue New EnglandSM Deductible

Summary of Benefits

Plan-Year Deductible: \$2,000/\$4,000

Effective on anniversary dates on or after January 1, 2012,
for accounts with 51+ eligible employees with fewer than
100 enrolled

 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 Care

Your Primary Care Provider.

When you enroll in HMO Blue New England, you must choose a primary care provider (PCP) for you and each member of your family from any New England state. There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; 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.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care—Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist. The specialist will usually be one your PCP knows, probably someone affiliated with your PCP's hospital or medical group. Your provider 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 certificate.

Your Deductible.

Your deductible is calculated on a plan-year basis.

If you are not sure when your plan year begins, contact Blue Cross Blue Shield. For some services, you must meet the plan-year deductible before benefits are provided. Your deductible is **\$2,000** for each member (or **\$4,000** per family). The following services are not subject to the deductible: office visits, preventive health services, emergency room visits, home health care, hospice services, medical formulas, all mental health services, and prescription drugs.

Your Out-of-Pocket Maximum.

When the money you pay for the deductible 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 calculating the out-of-pocket maximum.

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). You pay a **\$150** copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay.

HMO Blue New England Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the HMO Blue New England Service Area.

If you're traveling outside the service area and you need urgent or emergency care, go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please see your subscriber certificate for more information.

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

Covered Services	Your Cost
Outpatient Services (These services are not subject to the plan-year deductible) Emergency room visits	\$150 per visit, no deductible (waived if admitted or for observation stay)
Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams	Nothing, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Diabetic management services (first two visits per calendar year)*	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Mental health and substance abuse treatment	\$20 per visit, no deductible
Office visits <ul style="list-style-type: none"> • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers 	\$20 per visit, no deductible \$35 per visit, no deductible
Chiropractor services	\$35 per visit**, no deductible
Surgery in an office setting <ul style="list-style-type: none"> • When performed by your PCP or OB/GYN • When performed by other network providers 	\$20 per visit, no deductible \$35 per visit, no deductible
Home health care and hospice services	Nothing, no deductible
Other Outpatient Care Services (These services are subject to the plan-year deductible) Plan-year deductible	\$2,000 per member \$4,000 per family
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year***)	\$35 per visit after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$35 per visit after deductible
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	Nothing after deductible
Prosthetic devices	20% co-insurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% co-insurance after deductible
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible (no deductible for mental health care in a general hospital)
Mental hospital or substance abuse facility care (as many days as medically necessary)	Nothing, no deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

* These diabetic services are for diabetes evaluation and management services, diabetic eye exams, and/or diabetic foot care.

** For a network chiropractor in Maine, you pay \$25 per visit.

*** 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
Prescription Drug Benefits (These services are not subject to the plan-year deductible) At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No Deductible Nothing for Tier 1 Nothing for Tier 2 \$50 for Tier 3 \$15 for Tier 1 \$30 for Tier 2 \$50 for Tier 3
• Covered smoking cessation drugs* • All other covered drugs and supplies	
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No Deductible Nothing for Tier 1 Nothing for Tier 2 \$150 for Tier 3 \$15 for Tier 1 \$30 for Tier 2 \$150 for Tier 3 \$30 for Tier 1 \$60 for Tier 2 \$150 for Tier 3
• Covered smoking cessation drugs* • Certain covered drugs for: asthma, diabetes, coronary artery disease or risk for cardiovascular disease (concurrently taking high blood pressure medications and high cholesterol medications), and depression associated with any of these conditions* • All other covered drugs and supplies	

* For a list of these drugs, contact Blue Cross and Blue Shield or visit the Medication Benefit Options page in the Pharmacy Coverage section at www.bluecrossma.com.

Get the Most from Your Plan

Visit us at www.bluecrossma.com/membercentral or call 1-800-262-BLUE (2583) 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 to answer your health care questions 24 hours a day—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-800-262-BLUE (2583).

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. Your 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.