MASSACHUSETTS

Access Blue™ Saver

Summary of Benefits

Effective on anniversary dates on or after January 1, 2008

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that will be effective January 1, 2009, as part of the Massachusetts Health Care Reform Law.

Your Care

Access.

This plan gives you the option to go directly to a specialist or any doctor in the HMO Blue® network. **No referrals are ever needed.** Just show your Blue Cross Blue Shield ID card and receive care. Authorizations are required for some services. Please see your subscriber certificate for details.

Personal PCP Selection.

Although it's not required, it is recommended that you designate a Primary Care Physician (PCP). Having a designated PCP who knows you and your family's health history makes good health sense. Also, your out-of-pocket costs for some services will be less when you visit your designated PCP. 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 certificate.

You can designate a PCP in two ways: consult your Provider Directory and note your PCP on the Enrollment Form, or call the Member Service number on your ID card once you are a member.

There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the *HMO Blue 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. They 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 Deductible.

Your deductible is calculated on a plan-year basis. Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. The deductible is **$1,500** for each member in a plan-year (or **$3,000** per family). The deductible does not apply to outpatient preventive care services, including routine tests, and outpatient family planning services (see chart on opposite page). This deductible also applies to prescription drugs.

After your deductible has been met, you pay nothing for inpatient admissions, physician, or other provider services. **The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.**

Office Visit Copayments.

After your deductible, your copayment for office visits to your designated PCP, network OB-GYN physician, network nurse practitioner, or nurse midwife is **$15** per visit. Your copayment for office visits to other network providers is **$25** per visit. **No copayment applies to covered routine physicals.**

Out-of-Pocket Maximum.

When the money you have paid for the deductible, copayments, including prescription drug copayments, and any co-insurance equals **$5,000** for each 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, for the rest of that plan year. You will still have to pay any costs that are not included in the out-of-pocket maximum. **The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.**

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). After your deductible, there is a **$100** copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for observation stay.

HMO Blue Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts. Please see your subscriber certificate for a complete definition of the service area.

When Outside the HMO Blue 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 outside the service area must be authorized by the plan. Please see your subscriber certificate for more information.

Dependent Benefits.

This plan covers dependents to age 26, or for two calendar years after the dependent last qualified as a dependent under the Internal Revenue Code, 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

Covered Services	Your Cost
Preventive Care Outpatient Services (These services are not subject to the plan-year deductible)	
Well-child care visits (according to age-based schedule)	Nothing for network physician or nurse practitioner
Routine adult physical exams (one per calendar year)	Nothing for network physician or nurse practitioner
Routine GYN exams (one per calendar year)	$15 per visit
Routine vision exams (one every 24 months)	$15 per visit
Routine hearing exams • When performed by your designated PCP • When performed by other network providers	 $15 per visit $25 per visit
Family planning services–office visits • When performed by your designated PCP, network OB-GYN physician, network nurse practitioner or nurse midwife • When performed by other network providers	 $15 per visit $25 per visit
Other Outpatient Care Services (These services are subject to the plan-year deductible)	**Your Cost**
Plan-year deductible	$1,500 per individual membership/$3,000 per family membership. The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.
Plan-year out-of-pocket maximum (includes deductible, copayments, including prescription drug copayments and any co-insurance)	$5,000 per individual membership/$10,000 per family membership. The entire family out-of-pocket maximum must be satisfied before benefits are provided for any one member enrolled under a family membership.
Emergency room visits	$100 per visit after deductible (waived if admitted or for observation stay)
Office visits • When performed by your designated PCP, network OB-GYN physician, network nurse practitioner or nurse midwife • When performed by other network providers	 $15 per visit after deductible $25 per visit after deductible
Chiropractor services (up to 12 visits per calendar year for members age 16 or older)	$25 per visit after deductible
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*)	$25 per visit after deductible
Speech, hearing, and language disorder treatment–speech therapy	$25 per visit after deductible
Allergy injections only	Nothing after deductible
Diagnostic X-rays, lab tests, and other tests	Nothing after deductible
Home health care, including hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment and repairs–such as wheelchairs, crutches, hospital beds (up to $750 per calendar year**)	Deductible and all charges beyond the calendar-year maximum
Prosthetic devices and repairs	20% co-insurance after deductible
Surgery and related anesthesia • Office setting – When performed by your designated PCP or network OB-GYN physician – When performed by other network providers • Ambulatory surgical facility, hospital, or surgical day care unit	 $15 per visit after deductible $25 per visit after deductible Nothing after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	Nothing after 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

* No day limit applies when short-term rehabilitation therapy is furnished as part of covered home health care.
** 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 (These services are subject to the plan-year deductible)	**Your Cost**
Mental Health and Substance Abuse Treatment	
Biologically based conditions* Inpatient admissions in a general or mental hospital	Nothing after deductible
Outpatient visits	$15 per visit after deductible
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	Nothing after deductible
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing after deductible
Outpatient visits (up to 24 visits per calendar year)	$15 per visit after deductible
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	Nothing after deductible
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing after deductible
Outpatient visits (up to 8 visits per calendar year**)	$15 per visit after deductible
Prescription Drug Benefits	After the plan-year deductible, you pay the following copayments for retail and mail-service prescriptions:
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1 $25 for Tier 2 $45 for Tier 3
Through the mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1 $50 for Tier 2 $135 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 per 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 **1-800-262-BLUE (2583)** 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 1-800-262-BLUE (2583).

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com/getblue**.

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.

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