MASSACHUSETTS

# HMO Blue Options℠ v.3

Deductible Levels: $0/$500/$2,000

## Summary of Benefits

Effective on anniversary dates on or after January 1, 2010
for Individuals and Small Groups

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents effective January 1, 2010, as part of the Massachusetts Health Care Reform Law.

# Your Care

Within the HMO Blue Options network, hospitals and groups of primary care providers (PCPs) are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

**Where you receive care will determine your out-of-pocket costs for most services under the plan.** By choosing Enhanced Benefits Tier providers each time you get hospital or PCP care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes Massachusetts PCPs and hospitals that met our quality benchmark and our benchmark for lowest cost.
- **Standard Benefits Tier**—Includes Massachusetts PCPs and hospitals that met our quality benchmark and our benchmark for moderate cost. Also includes providers without sufficient data for measurement on one or both benchmarks. In limited circumstances, the Standard Benefits Tier includes certain providers whose scores would put them in the Basic Benefits Tier to provide geographic access for members.
- **Basic Benefits Tier**—Includes Massachusetts PCPs and hospitals that scored below our quality benchmark and/or our benchmark for moderate cost.

Note: PCPs were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Providers without sufficient data for either cost or quality are placed in the Standard Benefits Tier. Providers that do not meet benchmarks for one or both of the domains and hospitals that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your primary care provider and the facility where your provider has admitting privileges before you choose a PCP or receive care. For example, if you require hospital care and your Enhanced Benefits Tier PCP refers you to an Enhanced Benefits Tier hospital, you would pay the lowest cost sharing for both your PCP and hospital services. Or, if your Enhanced Benefits Tier PCP refers you to a Basic Benefits Tier hospital for care, you will pay the lowest copayments for PCP services, but the highest copayments for hospital services, except in an emergency.

## Your Primary Care Provider.

When you enroll, you must choose a primary care provider (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**; 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). Your PCP cares about your health, which is why, should you and your PCP decide you need a specialist, you'll be referred to the one your PCP determines is appropriate for treating your specific condition. If you have a specialist to whom you would like to be referred, discuss this with your doctor. 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.** For some services you must meet the plan-year deductible before benefits are provided. Your plan year will differ based on whether you are enrolled as a group member or as an individual. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. The deductibles are as follows:

**Enhanced Tier:** None

**Standard Tier: $500** per member/**$1,000** per family

**Basic Tier: $2,000** per member/**$4,000** per family

## Your Out-of-Pocket Maximum.

When the money you pay for the deductible, coinsurance, 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.

## Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts.

## When Outside the 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 exact service area details.

## 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 are admitted to the hospital or for an observation stay. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital. Any follow-up care must be arranged by your PCP.

## Dependent Benefits.

This plan covers dependents up to age 26, or for two years after the end of the calendar year in which they 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 for Enhanced Benefits Tier Network Providers | Your Cost for Standard Benefits Tier Network Providers | Your Cost for Basic Benefits Tier Network Providers |
|---|---|---|---|
| **Plan-year Deductible** | None | $500 per member<br>$1,000 per family | $2,000 per member<br>$4,000 per family |
| **Plan-year Out-of-Pocket Maximum** | $5,000 per member/$10,000 per family includes deductible, co-insurance, and copayments that are more than $100 per visit (if any), excluding prescription drug copayments | | |
| **Outpatient Care** | | | |
| Emergency room visits | $150 per visit (waived if admitted or for observation stay) | $150 per visit (waived if admitted or for observation stay) | $150 per visit (waived if admitted or for observation stay) |
| Well-child care visits | $15 per visit (no cost for immunizations and routine tests) | $25 per visit (no cost for immunizations and routine tests) | $50 per visit (no cost for immunizations and routine tests) |
| Routine adult physical exams, including related tests | $15 per visit (no cost for immunizations and routine tests) | $25 per visit (no cost for immunizations and routine tests) | $50 per visit (no cost for immunizations and routine tests) |
| Routine GYN exams, including related lab tests (one per calendar year) | $15 per visit (no cost for routine tests) | $15 per visit (no cost for routine tests) | $15 per visit (no cost for routine tests) |
| Office visits | | | |
| • PCP, network nurse practitioner, or nurse midwife (billed by PCP) | $15 per visit | $25 per visit | $50 per visit |
| • Network nurse practitioner or nurse midwife (not billed by PCP) | $15 per visit | $15 per visit | $15 per visit |
| • Other network providers | $50 per visit | $50 per visit | $50 per visit |
| Routine hearing exams | | | |
| • PCP | $15 per visit | $25 per visit | $50 per visit |
| • Other network providers | $50 per visit (no cost for routine tests and hospital services) | $50 per visit (no cost for routine tests and hospital services) | $50 per visit (no cost for routine tests and hospital services) |
| Routine vision exam (one every 24 months) | $50 per visit | $50 per visit | $50 per visit |
| Family planning services–office visits | | | |
| • PCP | $15 per visit | $25 per visit | $50 per visit |
| • Other network providers | $50 per visit | $50 per visit | $50 per visit |
| Chiropractor services (up to 12 visits per calendar year for members age 16 or older) | $50 per visit | $50 per visit | $50 per visit |
| Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*) | $50 per visit | $50 per visit | $50 per visit |
| Speech, hearing, and language disorder treatment–speech therapy | $50 per visit | $50 per visit | $50 per visit |
| Allergy injections only | Nothing | Nothing | Nothing |
| Home health care and hospice services | Nothing | Nothing | Nothing |
| Oxygen and equipment for its administration | Nothing | Nothing | Nothing |
| Prosthetic devices | 20% co-insurance | 20% co-insurance | 20% co-insurance |
| Durable medical equipment–such as wheelchairs, crutches, and hospital beds (up to $750 per calendar year**) | All charges beyond the calendar-year benefit maximum | All charges beyond the calendar-year benefit maximum | All charges beyond the calendar-year benefit maximum |
| Surgery and related anesthesia | | | |
| • Office setting: PCP/Other network providers | $15 per visit/$50 per visit | $25 per visit/$50 per visit | $50 per visit/$50 per visit |
| • Surgical day care unit | $150 per admission | $150 per admission after deductible<br>$200 per admission at selected hospitals*** | $1,000 per admission after deductible |
| • Ambulatory surgical facility | $150 per admission | $150 per admission | $150 per admission |
| Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans and nuclear cardiac imaging tests | | | |
| • General hospitals | Nothing | Nothing after deductible | Nothing after deductible |
| • Other covered providers | Nothing | Nothing | Nothing |
| CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | | | |
| • General hospitals | $50 per category per date of service | $50 per category per date of service after deductible | $450 per category per date of service after deductible |
| • Other covered providers | $50 per category per date of service | $50 per category per date of service | $50 per category per date of service |
| **Inpatient Care (and maternity care)** | | | |
| General hospital care (as many days as medically necessary) | $150 per admission | $150 per admission after deductible<br>$200 per admission at selected hospitals*** | $1,000 per admission after deductible |
| Chronic disease hospital care (as many days as medically necessary) | $150 per admission | $150 per admission | $150 per admission |
| Rehabilitation hospital care (up to 60 days per calendar year) | Nothing | Nothing | Nothing |
| Skilled nursing facility care (up to 100 days per calendar year) | Nothing | Nothing | Nothing |

* No visit 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.

*** To provide geographic access to members, the lower Standard Benefits Tier copayment applies for BHS Franklin Medical Center, Falmouth Hospital, Martha's Vineyard Hospital and Nantucket Cottage Hospital. The deductible does not apply to these admissions.

# Your Medical Benefits (continued)

| Covered Services | Your Cost for Enhanced Benefits Tier Network Providers | Your Cost for Standard Benefits Tier Network Providers | Your Cost for Basic Benefits Tier Network Providers |
|---|---|---|---|
| **Mental Health and Substance Abuse Treatment** | | | |
| **Biologically based conditions*** | | | |
| • Inpatient admissions in a general hospital (as many days as medically necessary) | $150 per admission | $150 per admission after deductible<br>$200 per admission at selected hospitals** | $1,000 per admission after deductible |
| • Inpatient admissions in a mental hospital or substance abuse facility (as many days as medically necessary) | $150 per admission | $150 per admission | $150 per admission |
| • Outpatient visits | $15 per visit | $15 per visit | $15 per visit |
| **Non-biologically based conditions** | | | |
| • Inpatient admissions in a general hospital (as many days as medically necessary) | $150 per admission | $150 per admission after deductible<br>$200 per admission at selected hospitals** | $1,000 per admission after deductible |
| • Inpatient admissions in a mental hospital (up to 60 days per calendar year) | $150 per admission | $150 per admission | $150 per admission |
| • Outpatient visits (up to 24 visits per calendar year) | $15 per visit | $15 per visit | $15 per visit |
| **Prescription Drug Benefits** | | | |
| At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill) | $15 for Tier 1<br>$30 for Tier 2<br>$50 for Tier 3 | $15 for Tier 1<br>$30 for Tier 2<br>$50 for Tier 3 | $15 for Tier 1<br>$30 for Tier 2<br>$50 for Tier 3 |
| Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill) | $30 for Tier 1<br>$60 for Tier 2<br>$150 for Tier 3 | $30 for Tier 1<br>$60 for Tier 2<br>$150 for Tier 3 | $30 for Tier 1<br>$60 for Tier 2<br>$150 for Tier 3 |

* Treatment of rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape and treatment for children under age 19, are covered to the same extent as biologically based conditions.

** To provide geographic access to members, the lower Standard Benefits Tier copayment applies for BHS Franklin Medical Center, Falmouth Hospital, Martha's Vineyard Hospital and Nantucket Cottage Hospital. The deductible does not apply to these admissions.

# 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 **1-800-262-BLUE (2583)** 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 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 |
| 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 additional 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 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.


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