Your Medical Benefits (continued)

Covered Services	Your Cost
Inpatient Care (including maternity care) General or chronic disease hospital care (for as many days as medically necessary)	20% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	20% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	20% co-insurance after deductible
Mental Health and Substance Abuse Treatment Biologically based conditions* Inpatient admissions in a general or mental hospital	20% co-insurance after deductible
Outpatient visits	$25 per visit, after deductible
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	20% co-insurance after deductible
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	20% co-insurance after deductible
Outpatient visits (up to 24 visits per calendar year)	$25 per visit, after deductible
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	20% co-insurance after deductible
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	20% co-insurance after deductible
Outpatient visits (up to 8 visits per calendar year**)	$25 per visit, after deductible

* 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.

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.

Program	Cost
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 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**.

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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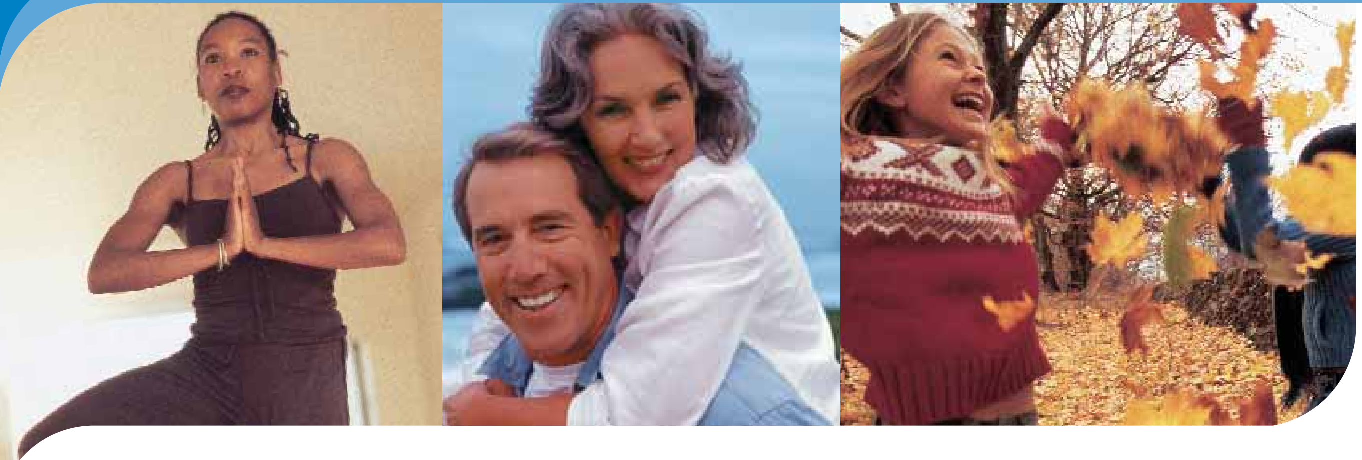

Access Blue Basic™ $2,000

Summary of Benefits

Effective on anniversary dates on or after January 1, 2009

✔ 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.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

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 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 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. For some services, you must meet a plan-year deductible before benefits are provided. The deductible is **$2,000** for each member (or **$4,000** per family). The following services are not subject to the deductible: preventive health services, prescription drugs, and emergency room visits. There is a separate **$250** per member (or **$500** per family) plan-year deductible for prescription drug benefits, then you pay a copayment or co-insurance (see chart on opposite page).

Out-of-Pocket Maximum.

When the money you pay for the deductible, 20 percent co-insurance, and copayments that are more than **$100** per visit (if any) 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. 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.

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 **$250** copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

Service Area.

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

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 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
Outpatient Care (These services are not subject to the plan-year deductible)	
Emergency room visits	$250 per visit (waived if admitted or for observation stay)
Well-child care visits • When performed by your designated PCP or network nurse practitioner • When performed by other network providers	 $25 per visit (no cost for immunizations and routine tests) $35 per visit (no cost for immunizations and routine tests)
Routine adult physical exams, including related tests • When performed by your designated PCP or network nurse practitioner • When performed by other network providers	 $25 per visit (no cost for routine tests) $35 per visit (no cost for routine tests)
Routine GYN exams, including related lab tests (one per calendar year)	$25 per visit (no cost for routine tests)
Routine vision exams (one every 24 months)	$25 per visit
Routine hearing exams • When performed by your designated PCP or network nurse practitioner • When performed by other network providers	 $25 per visit $35 per visit
Family planning services–office visits • When performed by your designated PCP, OB/GYN physician, nurse midwife, or network nurse practitioner • When performed by other network providers	 $25 per visit $35 per visit
Allergy injections only	Nothing
Other Outpatient Care (These services are subject to the plan-year deductible)	
Plan-year deductible	$2,000 per member $4,000 per family
Office visits • When performed by your designated PCP or network nurse practitioner • When performed by other network providers	 $25 per visit, after deductible $35 per visit, after deductible
Short-term rehabilitation therapy–physical and occupational (up to 20 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	20% co-insurance after deductible
Home health care and hospice services	20% co-insurance after deductible
Oxygen and equipment for its administration	20% co-insurance after deductible
Durable medical equipment–such as wheelchairs, crutches, and hospital beds (up to $750 per calendar year**)	20% co-insurance after deductible, then all charges beyond the calendar-year benefit maximum
Prosthetic devices	20% co-insurance after deductible
Surgery and related anesthesia • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	 20% co-insurance after deductible 20% co-insurance after deductible
Prescription Drug Benefits with BlueValue Rx℠ Formulary	After a $250 per member/$500 per family plan-year deductible (Tier 2 and Tier 3 only), you pay the following for retail and mail-service prescriptions:
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$15 for Tier 1 (No deductible) 50% co-insurance for Tier 2 50% co-insurance 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 (No deductible) 50% co-insurance for Tier 2 50% co-insurance for Tier 3

* 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.