BlueCross BlueShield

Preferred Blue® (PPO) Saver Middle Deductible

Plan-Year Deductible: $2000/$4,000

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.

Your Choice

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. Your deductible is the first **$2,000** of covered charges per individual membership each plan year (or **$4,000** per family membership). **This deductible does not apply to certain in-network or out-of-network preventive health services** (see chart on opposite page). For other covered services, this deductible applies to in-network and out-of-network services combined, including your prescription drug benefits. **The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.**

When You Choose Preferred Providers.

After your plan-year deductible has been met, you pay nothing for most in-network covered services. And, for outpatient preventive health services, you pay a **$20** copayment for each visit. **There is no deductible for these services.**

Please note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you're still covered, but your benefits will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your Provider Directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com** for Massachusetts providers.
- Visit the BlueCard® Provider Finder website at **www.bcbs.com/healthtravel/finder.html.**
- Call the BlueCard Program at **1-800-810-BLUE (2583)**, 24 hours a day, seven days a week.

When You Choose Non-Preferred Providers.

After your plan-year deductible has been met, you pay **20 percent** co-insurance for most out-of-network covered services. You also pay **20 percent** co-insurance for preventive health services; however, the plan-year deductible **does not** apply to these services.

Your Out-of-Pocket Maximum.

The out-of-pocket maximum applies to in-network and out-of-network covered services combined. When the money you pay for the deductible, 20 percent co-insurance, and copayments equals **$5,000** per individual membership in a plan year (or **$10,000** per family membership), benefits for that member (or that family) will be provided in full, based on the allowed charge, for the rest of that plan year. **The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.**

Emergency Room Services.

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, you pay a **$100** copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Home Health Care, and Individual Case Management. Information concerning Utilization Review is detailed in your subscriber certificate. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

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 Preventive Health Services (These services are not subject to the plan-year deductible.)	Your Cost In-Network	Your Cost Out-of-Network
Plan-year out-of-pocket maximum	$5,000 per individual membership/$10,000 per family membership for in-network and out-of-network services combined. The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.	
Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life • One visit per calendar year from age 2 through age 18	$20 per visit (no cost for routine tests)	20% co-insurance
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	$20 per visit (no cost for routine tests)	20% co-insurance
Routine GYN exams, including related lab tests (one per calendar year)	$20 per visit (no cost for routine tests)	20% co-insurance
Routine hearing exams	$20 per visit	20% co-insurance
Routine vision exams (one every 24 months)	$20 per visit	20% co-insurance
Family planning services–office visits	$20 per visit	20% co-insurance
Other Outpatient Care Services (These services are subject to the plan-year deductible.)	**Your Cost In-Network (after your deductible)**	**Your Cost Out-of-Network (after your deductible)**
Plan-year deductible	$2,000 per individual membership/$4,000 per family membership for in-network and out-of-network services combined. 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	$5,000 per individual membership/$10,000 per family membership for in-network and out-of-network services combined. The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.	
Emergency room visits	$100 per visit after deductible	$100 per visit after deductible
Allergy injections	Nothing after deductible	20% co-insurance after deductible
Clinic visits; physicians', podiatrists', and chiropractors' office visits	Nothing after deductible	20% co-insurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*)	Nothing after deductible	20% co-insurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	Nothing after deductible	20% co-insurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding routine tests	Nothing after deductible	20% co-insurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% co-insurance after deductible
Prosthetic devices	Nothing after deductible	20% co-insurance after deductible
Home health care and hospice services	Nothing after deductible	20% co-insurance after deductible
Durable medical equipment such as wheelchairs, crutches, hospital beds (up to a $1,500 calendar-year maximum**)	Deductible and all charges beyond the calendar-year maximum	Deductible, 20% co-insurance, and all charges beyond the calendar-year maximum
Surgery and related anesthesia	Nothing after deductible	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	20% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% co-insurance after deductible

* 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.

Your Medical Benefits (continued)

Covered Services	Your Cost In-Network (after your deductible)	Your Cost Out-of-Network (after your deductible)
Mental Health and Substance Abuse Treatment		
Biologically based conditions* Inpatient admissions in a general or mental hospital	Nothing after deductible	20% co-insurance after deductible
Outpatient visits	Nothing after deductible	20% co-insurance after deductible
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	Nothing after deductible	20% co-insurance after deductible
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Outpatient visits (up to 24 visits per calendar year)	Nothing after deductible	20% co-insurance after deductible
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Outpatient visits (up to 8 visits per calendar year**)	Nothing after deductible	20% co-insurance after deductible
Prescription Drug Benefits		
At retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	After deductible $10 for Tier 1 $25 for Tier 2 $45 for Tier 3	After deductible $20 for Tier 1 $50 for Tier 2 $90 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	After deductible $20 for Tier 1 $50 for Tier 2 $135 for Tier 3	

* Treatment of 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 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.

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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