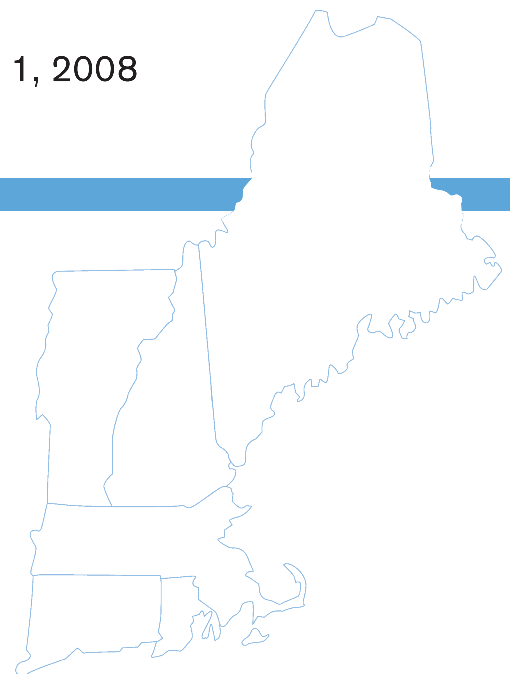
BlueCross BlueShield

Blue Choice® New England Value Plus

Summary of Benefits

Effective on anniversary dates on or after January 1, 2008



This Health Plan meets Minimum Creditable Coverage Standards which are effective January 1, 2009, as part of Massachusetts Health Care Reform Law.

Your Care

Your Primary Care Physician.

When you join Blue Choice New England, you choose a primary care physician (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 *HMO Blue New England 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.

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 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 certificates.

Out-of-Pocket Maximum for Certain Copayments.

When your care is provided or arranged by your Blue Choice New England PCP or by a network provider, you're protected by an out-of-pocket maximum of **$1,000** for each member (or **$2,000** per family). Only copayments for inpatient admissions, outpatient day surgical admissions, and emergency room visits will count toward this out-of-pocket maximum. You will still have to pay any costs that are not included in calculating the out-of-pocket maximum.

When You Choose to Receive Care on Your Own:

You also have the freedom to seek care without seeing your PCP first. When you seek care on your own from a participating provider, your out-of-pocket cost will be greater. If you require hospitalization, you, or someone on your behalf, should be sure to call us before you're admitted to make sure that you're covered.

You may have additional out-of-pocket expenses when you receive care without a referral from your PCP. These expenses include the following:

- For self-referred services, you must pay a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. The deductible is **$500** for each member (or **$1,000** per family). After you have met your deductible, you pay **20 percent** co-insurance for covered services.
- When the money you've paid for your 20 percent co-insurance equals **$1,000** for each member in a calendar year (or **$2,000** per family), then your benefits (or your family's benefits) are provided in full, based on the allowed charge, up to any benefit maximums for the rest of that calendar year. This co-insurance maximum is separate from the PCP/plan-approved copayment maximum. Your PCP/plan-approved copayments do not count toward your co-insurance maximum. You must still pay your copayment when it applies.
- For services not approved as PCP/plan-approved benefits, your health care plan provides up to a lifetime maximum benefit of $**2,000,000** for each member.

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). There is a **$50** copayment per visit for emergency room services. This copayment is waived if you are 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. Please see your subscriber certificate for a complete definition of the service area.

When Outside the HMO Blue New England Service Area.

If you're traveling outside the plan's 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. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

Dependent Benefits.

This plan covers dependents to age 26, or for two calendar years after the dependent is no longer claimed on the subscriber's or spouse's federal tax return, 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 certificates (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Major Medical Benefits (after your deductible)
Outpatient Care Emergency room visits	$50 per visit (waived if admitted or for observation stay)	20% co-insurance*
Well-child care visits	$15 per visit (no cost for immunizations and routine tests)	20% co-insurance
Routine adult physical exams, including related tests	$15 per visit (no cost for routine tests)	20% co-insurance
Routine GYN exams, including related lab tests (one per calendar year)	$15 per visit (no cost for routine tests)	20% co-insurance
Routine hearing exams	$15 per visit	20% co-insurance
Routine vision exams (one every 24 months)	$15 per visit	20% co-insurance
Family planning services—office visits	$15 per visit	20% co-insurance
Office visits	$15 per visit	20% co-insurance
Chiropractor services	$15 per visit	20% co-insurance
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year**)	$15 per visit	20% co-insurance
Speech, hearing, and language disorder treatment—speech therapy	$15 per visit	20% co-insurance
Allergy injections only	Nothing	20% co-insurance
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, and PET scans	Nothing	20% co-insurance
CT scans, MRIs, and PET scans	$25 per category per date of service***	20% co-insurance
Home health care, including hospice services	Nothing	20% co-insurance
Oxygen and equipment for its administration	Nothing	20% co-insurance
Prosthetic devices and repairs	Nothing	20% co-insurance
Durable medical equipment and repairs—such as wheelchairs, crutches, hospital beds (up to $750 per calendar year†)	All charges beyond the calendar-year benefit maximum	20% co-insurance and all charges beyond the calendar-year benefit maximum
Surgery and related anesthesia • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	 Nothing $150 per admission††	 20% co-insurance 20% co-insurance
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	$250 per admission††	20% co-insurance
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% co-insurance
Skilled nursing facility care	Nothing (up to 100 days per calendar year)	20% co-insurance (up to 100 days per calendar year less any PCP/plan-approved days used)
Prescription Drug Benefits 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 designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1 $50 for Tier 2 $90 for Tier 3	

* If this visit is for emergency care, you will only have to pay a $50 copayment per visit.

** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care.

*** When the copayments for CT scans, MRIs and/or PET scans add up to the total of $375 per member in a calendar year, you pay nothing for these tests for the remainder of that calendar year.

† No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

†† Copayments for consecutive inpatient admissions (or day surgery followed by inpatient care) within 30 days for the same or related illness will not exceed $500.

Your Medical Benefits (continued)

Covered Services	Your Cost For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Major Medical Benefits (after your deductible)
Mental Health and Substance Abuse Treatment Biologically based conditions† Inpatient admissions in a general hospital or mental hospital	$250 per admission††	20% co-insurance
Outpatient visits	$15 per visit	20% co-insurance
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	$250 per admission††	20% co-insurance
Inpatient admissions in a mental hospital or substance abuse treatment facility	$250 per admission†† (up to 60 days per calendar year)	20% co-insurance (up to 60 days per calendar year)
Outpatient visits	$15 per visit (up to 24 visits per calendar year)	20% co-insurance (up to 24 visits per calendar year)
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	$250 per admission††	20% co-insurance
Inpatient admissions in a substance abuse treatment facility	$250 per admission†† (up to 30 days per calendar year)	20% co-insurance (up to 30 days per calendar year)
Outpatient visits	$15 per visit (up to 8 visits per calendar year†††)	20% co-insurance (up to 8 visits per calendar year†††)

† 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.
†† Copayments for consecutive inpatient admissions (or day surgery followed by inpatient care) within 30 days for the same or related illness will not exceed $500.
††† 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.

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
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
Blue Care® Line to answer your health care questions 24 hours a day–call **1-888-247-BLUE (2583)**	No charge
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**.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificates and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificates 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 certificates and riders.

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