BlueCross BlueShield

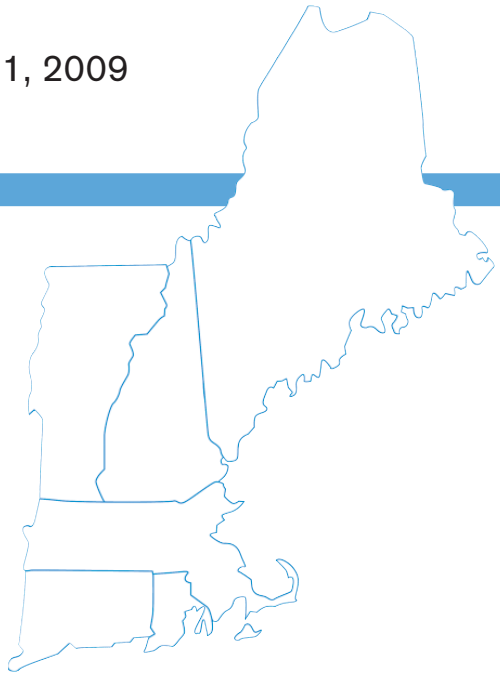
HMO Blue® New England

$500 Deductible

Summary of Benefits

Plan-Year Deductible: $500/$1,000

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.

An Association of Independent Blue Cross and Blue Shield Plans

Your Care

Your Primary Care Physician.

When you join HMO Blue New England Deductible, you must choose a primary care physician (PCP) for you and each member of your family from any New England state. 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). 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 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 deductible is **$500** for each member (or **$1,000** per family). The following services are not subject to the deductible: office visits, preventive health services, emergency room visits, home health care, hospice services, medical formulas, all mental health services, and prescription drugs.

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 **$100** copayment per visit for emergency room services. This copayment is waived if you're 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 exact service area details.

When Outside the HMO Blue New England 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 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 Services (These services are not subject to the plan-year deductible)	
Emergency room visits	$100 per visit, no deductible (waived if admitted or for observation stay)
Well-child care visits	$20 per visit, no deductible (no cost for immunizations or routine tests)
Routine adult physical exams, including related tests	$20 per visit, no deductible (no cost for routine tests)
Routine GYN exams, including related lab tests (one per calendar year)	$20 per visit, no deductible (no cost for routine tests)
Routine hearing exams	$20 per visit, no deductible
Routine vision exams (one every 24 months)	$20 per visit, no deductible
Family planning services–office visits	$20 per visit, no deductible
Office visits	$20 per visit, no deductible
Chiropractor services	$20 per visit, no deductible
Surgery in an office setting	$20 per visit, no deductible
Allergy injections only	Nothing, no deductible
Home health care and hospice services	Nothing, no deductible
Other Outpatient Care Services (These services are subject to the plan-year deductible)	
Plan-year deductible	$500 per member $1,000 per family
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*)	$20 per visit after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit after deductible
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, and PET scans	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Prosthetic devices	Nothing after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds (up to $750 per calendar year**)	After you meet your deductible, no cost up to benefit maximum; then, you pay all charges
Inpatient Care (including maternity care) (These services are subject to the plan-year deductible)	
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
Prescription Drug Benefits (These services are not subject to the plan-year deductible) At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No Deductible $15 for Tier 1 $30 for Tier 2 $50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No Deductible $30 for Tier 1 $60 for Tier 2 $150 for Tier 3

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or to diagnose and treat speech, hearing, and language disorders.

** No dollar limit or deductible 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
Mental Health and Substance Abuse Treatment (These services are not subject to the plan-year deductible)	
Biologically based conditions* Inpatient admissions in a general hospital or mental hospital	Nothing, no deductible
Outpatient visits	$20 per visit, no deductible
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	Nothing, no deductible
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing, no deductible
Outpatient visits (up to 24 visits per calendar year)	$20 per visit, no deductible
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	Nothing, no deductible
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing, no deductible
Outpatient visits (up to 8 visits per calendar year**)	$20 per visit, no 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.

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
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**.

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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