



MASSACHUSETTS



Comprehensive Major Medical

Calendar-Year Deductible: \$500/\$1,000

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.

About the Plan

You Are Free to Choose.

With Comprehensive Major Medical, you may use any Blue Cross Blue Shield-participating provider in the United States. In Massachusetts, all general hospitals and most physicians participate with Blue Cross Blue Shield. There are no claim forms for services you receive in Massachusetts by a participating provider. With your health care plan, there are reasonable out-of-pocket expenses. And, your plan gives you nationwide access to participating hospitals and medical, surgical, and other health care providers.

To Find a Provider.

To find a participating provider within Massachusetts, call our Physician Selection Service at **1-800-821-1388** or visit our website at www.bluecrossma.com. If you're receiving care outside of Massachusetts and you need to locate a doctor or hospital that participates with the local Blue Cross Blue Shield plan, or if you need help finding a specialist, just call **1-800-810-BLUE (2583)**.

The BlueCard® Program.

The BlueCard Program gives you access to participating providers throughout the United States. There are no claims to submit, no paperwork, and no up-front costs. You need only go to a BlueCard-participating doctor or hospital and show your ID card when you need care. You simply pay your deductible and co-insurance as usual. If you choose to see a non-participating provider, you may have to file the claim yourself to be reimbursed for your expenses. (Please note: participating providers are restricted from billing you for the balance of their charges that exceed the negotiated discount amount except as provided otherwise by law.)

You can find participating providers or check a provider's current status in several ways:

- Call **1-800-810-BLUE (2583)**. Please have your ID card ready. If you have not received your ID card, let the representative know that you are looking for participating providers in the area in which you wish to seek care.
- Visit the BlueCard Provider Finder website at www.bcbs.com/healthtravel/finder.html.

Please note: If you are outside the United States and need medical care, call **1-800-810-BLUE (2583)**. A medical assistance coordinator, along with a nurse, will make a doctor's appointment for you or arrange for hospitalization if necessary.

Lifetime Maximum.

Each member has a **\$2,000,000** lifetime benefit maximum for all covered services.

Your Deductible.

Your deductible is calculated on a calendar-year basis.

Your deductible is the amount of money you pay out-of-pocket each calendar year before you can receive coverage for most benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible is the first **\$500** of covered charges per member each calendar year (or **\$1,000** per family). **This deductible does not apply to certain preventive health services or to prescription drug benefits** (see chart on opposite and back pages). Covered charges for any services you receive during October, November, and December that are applied toward your deductible, will also be applied toward your deductible for the next calendar year.

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 a member in a calendar 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 calendar 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.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Concurrent Review and Discharge Planning, 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 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 certificate (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost (after your deductible)
Outpatient Care	
Emergency room visits	20% co-insurance
Well-child care exams, including related tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • Six 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 11 • One visit every two calendar years from age 12 through age 18 	20% co-insurance, no deductible
Routine adult physical (or GYN) exams, according to age-based schedule (up to a benefit maximum of \$75 per visit): <ul style="list-style-type: none"> • Once every five calendar years from age 19 through age 29 • Once every three calendar years from age 30 through age 39 • Once every two calendar years from age 40 through age 54 • Once every calendar year age 55 and older 	Charges over the \$75 allowance, no deductible
Family planning services—office visits	20% co-insurance, no deductible
Allergy injections	20% co-insurance
Clinic visits; physicians', chiropractors', and podiatrists' office visits	20% co-insurance
Diagnostic X-rays, lab tests, and other tests	20% co-insurance
Durable medical equipment and repairs—such as wheelchairs, crutches, hospital beds	20% co-insurance
Home health care, including hospice services	20% co-insurance
Oxygen and equipment for its administration	20% co-insurance
Prosthetic devices and repairs	20% co-insurance
Short-term rehabilitation therapy—physical and occupational	20% co-insurance
Speech, hearing, and language disorder treatment—speech therapy	20% co-insurance
Surgery and related anesthesia <ul style="list-style-type: none"> • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit 	20% co-insurance 20% co-insurance
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	20% co-insurance
Rehabilitation hospital care (as many days as medically necessary)	20% co-insurance
Skilled nursing facility care (as many days as medically necessary)	20% co-insurance
Mental Health and Substance Abuse Treatment	
Biologically based conditions*	
Inpatient admissions in a general hospital or mental hospital	20% co-insurance
Outpatient visits	20% co-insurance
Non-biologically based mental conditions (includes drug addiction and alcoholism)	
Inpatient admissions in a general hospital	20% co-insurance
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	20% co-insurance
Outpatient visits (up to a maximum of 24 visits per calendar year)	20% co-insurance
Alcoholism treatment (in addition to non-biologically based mental conditions)	
Inpatient admissions in a general hospital	20% co-insurance
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	20% co-insurance
Outpatient visits (up to a maximum of 8 visits per calendar year)**	20% co-insurance

* 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 each calendar year.

Your Medical Benefits (continued)

Covered Services	Your Cost
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No Deductible \$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)	No Deductible \$20 for Tier 1 \$50 for Tier 2 \$90 for Tier 3

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 <i>Babies</i> [®]	No charge
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
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.

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.

