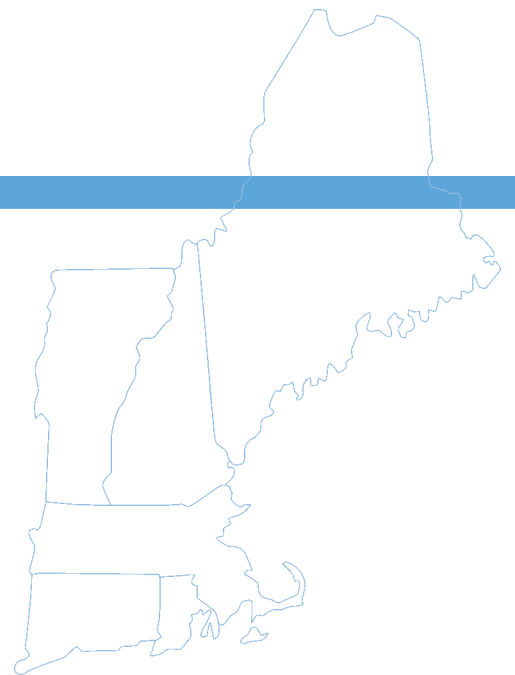




HMO Blue[®] New England Deductible

Summary of Benefits



Your Care

Your Primary Care Physician.

Your primary care physician (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 your PCP determines that you need to see a specialist, you'll be referred to the appropriate specialist affiliated with your PCP's network, which is also the network where you'll receive inpatient care if needed. 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.

Choosing a Primary Care Physician.

When you join HMO Blue New England Deductible, you must choose a 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 *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.

Urgent Care Away from Home.

If you're traveling outside of the plan service area (the state in which your PCP is located) and you need urgent care, go to the nearest medical facility. You, or someone on your behalf, must notify your PCP within 48 hours (no call is needed if you go to an emergency room). And, any follow-up care must be arranged by your PCP.

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 **\$100** copayment for emergency room services, which is waived if you're admitted to the hospital or the stay is for observation. Any 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 certificate (and riders, if any) for exact coverage details.

Your Medical Benefits

With this health care plan,* you have benefits with no waiting periods and virtually no claim forms. And, in case of an emergency, you have Blue Cross Blue Shield's immediate name recognition wherever you travel.

For some services, you must meet a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible is **\$1,000** for each member, or **\$2,000** for all family members covered under the same membership. 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.

Covered Services	Your Cost
Outpatient Services (These services are not subject to the calendar-year deductible)	
Emergency room visits	\$100 per visit, no deductible (waived for observation stay or if admitted)
Well-child care	\$20 per visit, no deductible
Routine exams (including one GYN exam per calendar year), including related lab tests	\$20 per visit, no deductible
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, including hospice services	Nothing, no deductible
Other Outpatient Care Services (These services are subject to the calendar-year deductible)	
Calendar-year deductible	\$1,000 per member \$2,000 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	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 and repairs—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 calendar-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 Benefit (These services are not subject to the calendar-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 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 \$100 for Tier 3

* In Vermont, this is called Network Blue New England.

** 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 calendar-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 <i>Babies</i> [®]	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 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.