



MASSACHUSETTS



Access Blue BasicSM

A Commonwealth Health Connector Approved Plan

Summary of Benefits

Effective on anniversary dates on or after January 1, 2012,
for Individuals and Small Groups

 This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, as part of the Massachusetts Health Care Reform Law.

Your Care

Access.

This plan gives you the option to go directly to a specialist or any doctor in the HMO Blue® network without a referral. **No referrals are ever needed.** Just show your Blue Cross Blue Shield ID card and receive care. However, authorizations are required for some services. Please see your subscriber certificate for details.

Personal PCP Selection.

Although it's not required, it is recommended that you designate a primary care provider (PCP). Having a designated PCP who knows you and your family's health history makes good health sense. Also, your out-of-pocket costs for some services will be less when you visit your designated PCP. Your provider 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.

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. They 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 Deductible.

Your deductible is calculated on a plan-year basis. For some services, you must meet a plan-year deductible before benefits are provided. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. The deductible is **\$2,000** for each member (or **\$4,000** per family). The following services are not subject to the deductible: preventive health services, prescription drugs, and office visits for which a copayment applies. There is a separate **\$250** per member (or **\$500** per family) plan-year deductible for retail and mail service prescription drug benefits (Tier 2 and Tier 3 only), then you pay a copayment.

Office Visit Copayments.

Your copayment for office visits to your designated PCP, OB-GYN physician, nurse practitioner, or nurse midwife is **\$30** per visit. Your copayment for office visits to other network providers is **\$45** per visit.

Out-of-Pocket Maximum.

When the money you pay for the medical deductible, co-insurance, and copayments equals **\$5,000** for each member in a plan year (or **\$10,000** per family), benefits for that member (or that family) will be provided in full for those covered services, for the rest of that plan 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.

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). After your deductible, you pay a **\$150** copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for observation stay.

Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts.

When Outside the Service Area.

If you're traveling outside the service area and you need urgent or emergency care, you may 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 outside the service area must be authorized by the plan. Please see your subscriber certificate for more information.

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. 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)	
Well-child care visits	Nothing
Routine adult physical exams, including related tests	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing
Routine hearing exams	Nothing
Routine vision exams (one every 24 months)	Nothing
Family planning services—office visits	Nothing
Office visits • When performed by your designated PCP, OB-GYN physician, nurse practitioner, or nurse midwife • When performed by other network providers	\$30 per visit \$45 per visit
Surgery in an office setting • When performed by your PCP or OB/GYN • When performed by other network providers	\$30 per visit \$45 per visit
Short-term rehabilitation therapy—physical and occupational (up to 20 visits per calendar year*)	\$45 per visit
Speech, hearing, and language disorder treatment—speech therapy	\$45 per visit
Other Outpatient Care Services (These services are subject to the plan-year deductible) Plan-year deductible	
	\$2,000 per member \$4,000 per family
Emergency room visits	\$150 per visit after deductible
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, and hospital beds	20% co-insurance after deductible
Prosthetic devices	20% co-insurance after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$250 per admission after deductible
Prescription Drug Benefits with BlueValue RxSM Formulary[†]	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	After the \$250 per member/\$500 per family plan-year deductible (Tier 2 and Tier 3 only), you pay: \$10 for Tier 1 (no deductible) \$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)	After the \$250 per member/\$500 per family plan-year deductible (Tier 2 and Tier 3 only), you pay: \$20 for Tier 1 (no deductible) \$60 for Tier 2 \$90 for Tier 3

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

† Your plan provides coverage of certain maintenance medications through an Exclusive Home Delivery Program. This program helps you get maintenance medications in a reliable, convenient way, while keeping your plan's costs down. A maintenance medication is a prescription drug that treats an ongoing condition such as diabetes or high blood pressure. Under your Exclusive Home Delivery Program, you can get up to a 1-month supply of a maintenance medication two times from a local participating pharmacy during a 180-day period. After that, your plan will cover the medication only if you order it from the Express Scripts Mail-Service Pharmacy.

Your Medical Benefits (continued)

Covered Services	Your Cost
Inpatient Care (including maternity care) General or chronic disease hospital care (for as many days as medically necessary)	\$500 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	\$500 per admission after deductible
Skilled nursing facility care (up to 100 days per calendar year)	\$500 per admission after deductible
Mental Health and Substance Abuse Treatment Biologically based conditions* • Inpatient admissions in a general hospital, mental hospital, or substance abuse facility • Outpatient visits	\$500 per admission after deductible \$30 per visit, no deductible
Non-biologically based conditions • Inpatient admissions in a general hospital • Inpatient admissions in a mental hospital (up to 60 days per calendar year) • Outpatient visits (up to 24 visits per calendar year)	\$500 per admission after deductible \$500 per admission after deductible \$30 per visit, no deductible

* Treatment of rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape and treatment for children under age 19, are covered to the same extent as biologically based conditions.

Get the Most from Your Plan

Visit us at www.bluecrossma.com/membercentral or call 1-800-262-BLUE (2583) to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

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
Blue Care Line SM —A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional 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.

