MASSACHUSETTS

Access Blue Basic℠ Saver

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.

You can designate a PCP in two ways: consult your Provider Directory and note your PCP on the Enrollment Form, or call the Member Service number on your ID card once you are a member.

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. Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. The deductible is **$3,000** for each member in a plan-year (or **$5,950** per family). The deductible does not apply to outpatient preventive care services, including routine tests, and outpatient family planning services (see chart on opposite page). This deductible also applies to prescription drugs.

After your deductible has been met, you pay **35 percent** co-insurance for some services. **The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.**

Out-of-Pocket Maximum.

When the money you have paid for any deductible, copayments, and co-insurance equals **$5,800** per individual membership in a plan-year (or **$11,600** per family membership), benefits for that member (or that family) will be provided in full for the rest of that plan year. **The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.**

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 **$250** 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, 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
Preventive Care 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 (one per calendar year)	Nothing
Routine hearing exams	Nothing
Family planning services–office visits	Nothing
Routine vision exams (one every 24 months)	Nothing
Covered Services (These services are subject to the plan-year deductible)	**Your Cost**
Plan-year deductible	$3,000 per individual membership/$5,950 per family membership. The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.
Plan-year out-of-pocket maximum (includes any deductible, copayments, and co-insurance)	$5,800 per individual membership/$11,600 per family membership. The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.
Emergency room visits	$250 per visit after deductible (waived if admitted or for observation stay)
Office visits	
• When performed by your designated PCP, OB-GYN physician, or nurse midwife	$60 per visit after deductible
• When performed by other network providers	$75 per visit after deductible
Short-term rehabilitation therapy–physical and occupational (up to 20 visits per calendar year*)	$75 per visit after deductible
Speech, hearing, and language disorder treatment–speech therapy	$75 per visit after deductible
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	35% co-insurance after deductible
Home health care and hospice services	35% co-insurance after deductible
Oxygen and equipment for its administration	35% co-insurance after deductible
Durable medical equipment–such as wheelchairs, crutches, and hospital beds	35% co-insurance after deductible
Prosthetic devices	35% co-insurance after deductible
Surgery and related anesthesia	35% co-insurance after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	35% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	35% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	35% co-insurance after deductible
Mental Health and Substance Abuse Treatment (These services are subject to the plan-year deductible)	
Biologically based conditions**	
• Inpatient admissions in a general hospital, mental hospital, or substance abuse facility	35% co-insurance after deductible
• Outpatient visits	$60 per visit after deductible
Non-biologically based conditions	
• Inpatient admissions in a general hospital	35% co-insurance after deductible
• Inpatient admissions in a mental hospital (up to 60 days per calendar year)	35% co-insurance after deductible
• Outpatient visits (up to 24 visits per calendar year)	$60 per visit after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** 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.

Your Medical Benefits (continued)

Covered Services	Your Cost
Prescription Drug Benefits with BlueValue Rx℠ Formulary†	After the plan-year deductible, your pay the following copayments for retail and mail service prescriptions:
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$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)	$30 for Tier 1 $60 for Tier 2 $150 for Tier 3

†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.

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℠ to answer your health care questions 24 hours a day–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..

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