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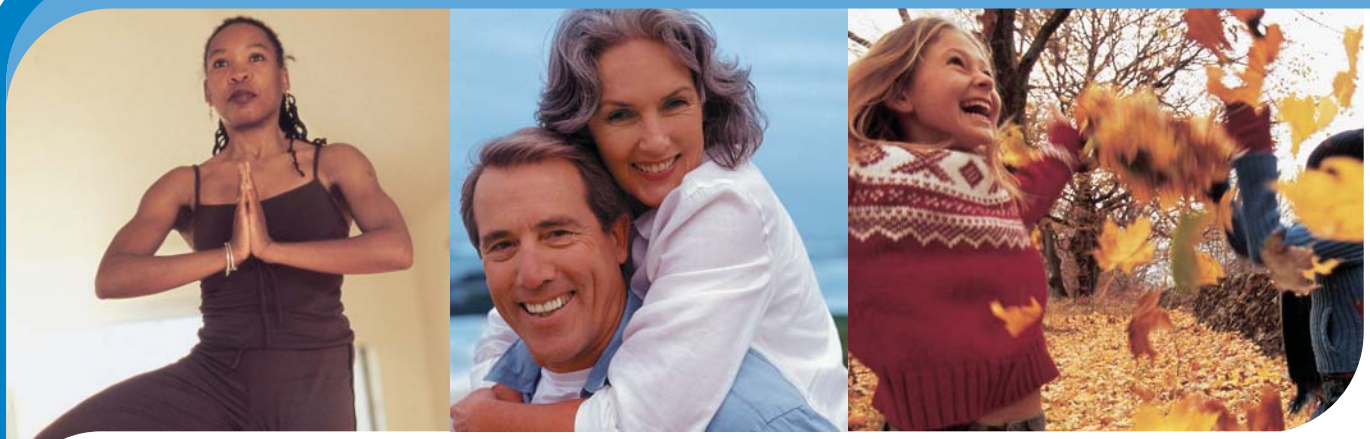

HMO Blue® Premier Value

w/coinsurance

Summary of Benefits

Effective on anniversary dates on or after April 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.

Your Care

Your Primary Care Physician.

When you join HMO Blue, you must choose a primary care physician (PCP) for you and each member of your family. 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). Your HMO Blue PCP cares about your health, which is why, should you and your PCP decide you need a specialist, you'll be referred to the one your PCP determines is appropriate for treating your specific condition. If you have a specialist to whom you would like to be referred, discuss this with your doctor. 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 Inpatient Benefits.

Your deductible is calculated on a plan-year basis. Your plan year will differ based on whether you are enrolled as a group member or as an individual. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. For inpatient admissions in a general or chronic disease hospital, you must meet the plan-year deductible before benefits are provided. Your deductible is **$1,000** for each member (or **$2,500** per family). After your deductible has been met, full coverage for inpatient admissions will be provided for the remainder of that plan year for these covered services. Inpatient admissions in a general hospital for mental health and substance abuse treatment are not subject to the inpatient deductible.

Out-of-Pocket Maximum.

When the money you pay for the deductible, co-insurance, and copayments that are more than **$100** per visit (if any) equals **$2,000** for a member in a plan year (or **$4,000** 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 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). You pay a **$150** copayment per visit for emergency room visits. This copayment is waived if you are admitted to the hospital or for an observation stay.

HMO Blue Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts. Please see your subscriber certificate for exact service area details.

When Outside the HMO Blue 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 up to age 26, or for two years after the end of the calendar year in which he or she 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 Care	
Emergency room visits	$150 per visit (waived if admitted or for observation stay)
Well-child care visits	$15 per visit (no cost for immunizations and routine tests)
Routine adult physical exams, including related tests	$15 per visit (no cost for immunizations and routine tests)
Routine GYN exams, including related lab tests (one per calendar year)	$15 per visit (no cost for routine tests)
Routine hearing exams	$15 per visit
Routine vision exams (one every 24 months)	$15 per visit
Family planning services–office visits	$15 per visit
Office visits When performed by your PCP, OB/GYN, nurse practitioner, or nurse midwife When performed by other network providers	 $25 per visit $40 per visit (or for home visits and hospital* services, nothing)
Chiropractor services (up to 12 visits per calendar year for members age 16 or older)	$40 per visit
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year**)	$40 per visit
Speech, hearing, and language disorder treatment–speech therapy	$40 per visit
Allergy injections only	Nothing
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, and PET scans	35% co-insurance
Oxygen and equipment for its administration	Nothing
Home health care and hospice services	Nothing
Durable medical equipment–such as wheelchairs, crutches, hospital beds (up to $750 per calendar year***)	All charges beyond the calendar-year benefit maximum
Prosthetic devices	20% co-insurance
Surgery and related anesthesia • Office setting When performed by your PCP, OB/GYN When performed by other network providers • Ambulatory surgical facility, hospital, or surgical day care unit	 $25 per visit $40 per visit 35% co-insurance
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	$1,000 deductible per member per plan year† $2,500 deductible per family per plan year†
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing
Prescription Drug Benefits	
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

* If the network provider's office is located at, or professional services are billed by, the hospital, you must pay the cost-share amount that you would normally pay for an office visit.

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

*** No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

† Once the plan-year deductible has been met, full coverage for covered admissions will be provided for the remainder of that plan year.

Your Medical Benefits (continued)

Covered Services	Your Cost
Mental Health and Substance Abuse Treatment	
Biologically based conditions* Inpatient admissions in a general hospital	Nothing
Outpatient visits	$25 per visit
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	Nothing
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing
Outpatient visits (up to 24 visits per calendar year)	$25 per visit
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	Nothing
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing
Outpatient visits (up to 8 visits per calendar year**)	$25 per visit

* 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 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 information which outlines these special programs.

www.livinghealthybabies.com	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
Safe Beginnings–discounts on 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**.

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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