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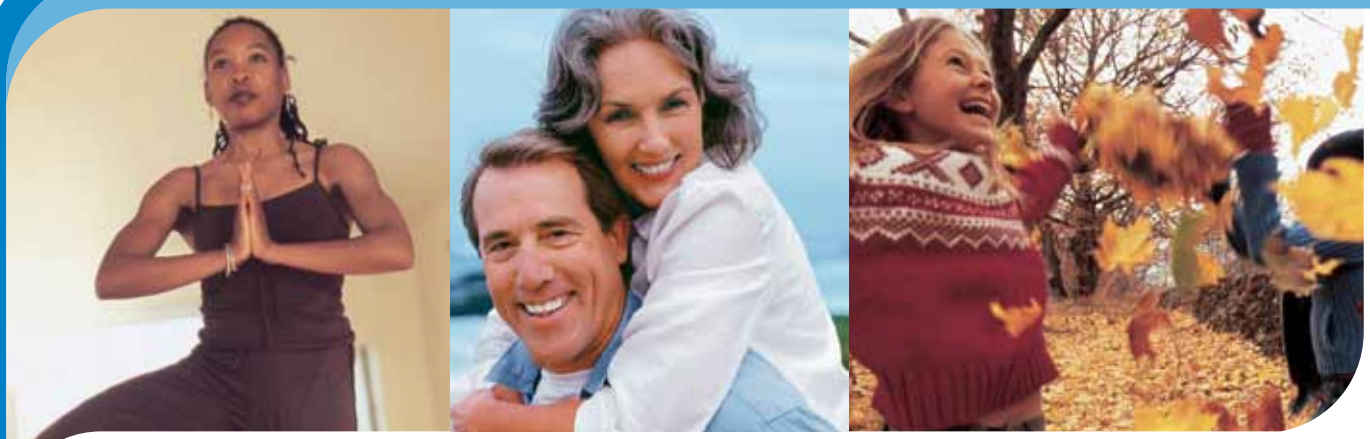

HMO Blue Deductible Plan℠

with Hospital Choice Cost Sharing

Plan-Year Deductible: $2,000/$4,000

Summary of Benefits

Effective on anniversary dates on or after January 1, 2011,
for Individuals and Small Groups

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

Your Care

Your Primary Care Provider

When you enroll in HMO Blue, you must choose a primary care provider (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 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 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.

Your Cost Share.

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive certain services at or by "higher cost share hospitals," including inpatient admissions, outpatient day surgery, and some other hospital outpatient services. Please see the chart on opposite and back pages for cost share amounts.

Please note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your PCP refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Bay State Medical Center
- Berkshire Medical Center
- Brigham and Women's Hospital
- Cape Cod Hospital
- Caritas St. Anne's Hospital
- Children's Hospital Medical Center
- Cooley Dickinson Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Harrington Memorial Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

Your Deductible.

Your deductible is calculated on a plan-year basis. For some services, you must meet the plan-year deductible before benefits are provided. 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. The deductible is **$2,000** for each member (or **$4,000** per family). The following services are not subject to the deductible: emergency room visits, preventive health services, office visits, all mental health services and prescription drugs.

Your 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 plan 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 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 calculating 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 services. 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.

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, 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 Care **(These services are not subject to the plan-year deductible)** Emergency room visits	$150 per visit (waived if admitted or for observation stay)
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 PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	$20 per visit $35 per visit
Chiropractor services (up to 12 visits per calendar year for members age 16 and older)	$35 per visit
Surgery in an office setting • When performed by your PCP or OB/GYN • When performed by other network providers	$20 per visit $35 per visit
Allergy injections only	Nothing
Other Outpatient Care **(These services are subject to the plan-year deductible)** Plan-year deductible	$2,000 per member $4,000 per family
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*) • When performed in other hospitals or by other network providers • When performed at or by higher cost-share hospitals	$35 per visit after deductible $70 per visit after deductible
Speech, hearing, and language disorder treatment–speech therapy • When performed in other hospitals or by other network providers • When performed at or by higher cost-share hospitals	$35 per visit after deductible $70 per visit after deductible
Ambulatory surgical facility, hospital outpatient department, or surgical day care unit • When performed in other hospitals or by other network providers • When performed in higher cost-share hospitals	Nothing after deductible $1,000 after deductible
Diagnostic X-rays and other imaging tests • When performed in other hospitals or by other network providers • When performed at or by higher cost-share hospitals	Nothing after deductible $100 per service date after deductible
Diagnostic lab tests • When performed in other hospitals or by other network providers • When performed at or by higher cost-share hospitals	Nothing after deductible $35 per service date after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests • When performed in other hospitals or by other network providers • When performed at or by higher cost-share hospitals	Nothing after deductible $450 per category per service date 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, hospital beds (up to $750 per calendar year**)	Deductible and all charges beyond the calendar-year benefit maximum
Prosthetic devices	20% co-insurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care and for the treatment of autism spectrum 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
Inpatient Care (including maternity care) • In other general hospitals (as many days as medically necessary) • In higher cost-share hospitals (as many days as medically necessary)	 Nothing after deductible $1,000 per admission after deductible
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
Mental Health and Substance Abuse Treatment Biologically based conditions* • Inpatient admissions in other general hospitals • Inpatient admissions in higher cost-share hospitals • Inpatient admissions in a mental hospital or substance abuse facility • Outpatient visits	 Nothing Nothing Nothing $20 per visit
Non-biologically based mental conditions • Inpatient admissions in other general hospitals • Inpatient admissions in higher cost-share hospitals • Inpatient admissions in a mental hospital (up to 60 days per calendar year) • Outpatient visits (up to 24 visits per calendar year)	 Nothing Nothing Nothing $20 per visit
Prescription Drug Benefits **(These services are not subject to the plan-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 designated 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 $150 for Tier 3

*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.

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 that outlines these special programs.

www.livinghealthybabies.com	No additional 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 Health 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 additional charge
Living Health 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 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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