BlueCross® BlueShield®

SUMMARY OF BENEFITS

Access Blue New England℠ Basic Saver

Effective on anniversary dates on or after January 1, 2015, for Individuals and Small Groups

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2014, 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 New England® 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.

Your Primary Care Provider.

When you enroll in Access Blue New England Saver, you must choose a primary care provider (PCP) who is available to accept you and your family members and participates in our network of providers throughout the New England states. For children, you may designate a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYNs: 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.

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 Deductible.

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. Your deductible is **$3,300** per individual membership (or **$6,550** per family membership).**The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.**

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services.
Your out-of-pocket maximum is **$6,450** per individual membership (or **$12,900** 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 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, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

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.

Dependent Benefits.

This plan covers dependent suntil the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. Please see your subscriber certificate (and riders, if any) for exact coverage details.

Pediatric Dental Benefits.

Your medical plan coverage includes a separate dental policy that covers pediatric dental benefits for members under age 19 as required under the federal Patient Protection and Affordable Care Act.

You must meet a plan-year deductible for certain covered dental services. Your deductible is **$50** per member (no more than **$150** for three or more members under age 19 enrolled under the same family membership).

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and coinsurance for covered dental services. Your out-of-pocket maximum is **$350** per member (no more than **$700** for two or more members under age 19 enrolled under the same family membership).

To find participating dental providers, visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com/findadoctor** or call our Physician Selection Service at **1-800-821-1388**.

Your Medical Benefits

Covered Services (These services are not subject to the plan-year deductible)	Your Cost
Preventive Care Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams	Nothing, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Diabetic management services (first two visits per calendar year*)	Nothing, no deductible
Covered Services **(These services are subject to the plan-year deductible)**	**Your Cost**
Plan-year deductible	$3,300 per individual membership/$6,550 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 coinsurance)	$6,450 per individual membership/$12,900 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.
Other Outpatient Care Emergency room visits	$250 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	 $60 per visit after deductible $75 per visit after deductible
Mental health or substance abuse treatment	$60 per visit after deductible
Chiropractors' office visits	$75 per visit after deductible
Short-term rehabilitation therapy–physical and occupational (up to 60 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% coinsurance after deductible
Home health care and hospice services	35% coinsurance after deductible
Oxygen and equipment for its administration	35% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, and hospital beds	35% coinsurance after deductible***
Prosthetic devices	35% coinsurance after deductible
Surgery and related anesthesia • Office setting – When performed by your PCP or OB-GYN – When performed by other network providers • Ambulatory surgical facility, hospital, or surgical day care unit	 $60 per visit† after deductible $75 per visit† after deductible 35% coinsurance after deductible
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	35% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	35% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	35% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	35% coinsurance after deductible

* These diabetic services are for diabetes evaluation and management services, diabetic eye exams, and/or diabetic foot care.

** 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.

*** Cost share waived for one breast pump per birth.

† Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Prescription Drug Benefits*	Your Cost**
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	
• Covered smoking cessation drugs***	Nothing, no deductible for Tier 1 Nothing, no deductible for Tier 2 $50 after deductible for Tier 3
• All other covered drugs and supplies	$15 after deductible for Tier 1† $30 after deductible for Tier 2 $50 after deductible for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	
• Covered smoking cessation drugs***	Nothing, no deductible for Tier 1 Nothing, no deductible for Tier 2 $150 after deductible Tier 3
• Certain covered drugs for: asthma, diabetes, coronary artery disease or risk for cardiovascular disease (concurrently taking high blood pressure medications and high cholesterol medications), and depression associated with any of these conditions***	$15, no deductible for Tier 1 $30, no deductible for Tier 2 $150, no deductible for Tier 3
• All other covered drugs and supplies	$30 after deductible for Tier 1† $60 after deductible for Tier 2 $150 after deductible for Tier 3

* Cost share waived for certain preventive drugs.
** Copayment waived for certain orally-administered anticancer drugs.
*** For a list of these drugs, contact Blue Cross and Blue Shield or visit the Value-Based Benefits page in the Pharmacy Coverage section at www.bluecrossma.com.
† Cost share waived for birth control.

Pediatric Dental Benefits for Members under age 19*	Your Cost
Plan-year deductible for Group 2 and Group 3 services	$50 per member $150 for three or more members
Plan-year out-of-pocket maximum	$350 per member $700 for two or more members
Group 1 Preventive and Diagnostic Services: oral exams, X-rays, and routine dental care	Nothing, no deductible
Group 2 Basic Restorative Services: fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance	25% coinsurance after deductible
Group 3 Major Restorative Services: tooth replacement, resin crowns, and occlusal guards	50% coinsurance after deductible
Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member	50% coinsurance, no deductible

* All services are limited to an age-based schedule and/or frequency. For a complete list of covered services or additional information, refer to your subscriber certificate.

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 or for fitness classes This fitness benefit applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your subscriber certificate for details.)	Reimbursement for membership fees for up to 3 consecutive months of one annual family or individual membership at a health club or 10 fitness classes, per individual or family per calendar year
A Weight Loss Program Benefit toward participation in a qualified weight loss program This weight loss program benefit applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your subscriber certificate for details.)	Reimbursement for up to 3 months participation fees per individual or family per calendar year
Blue Care Line℠—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 for members over age 21; 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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