BlueCross® BlueShield®

SUMMARY OF BENEFITS

Network Blue New England Options℠ Deductible v.4

This health plan includes a tiered provider network called HMO Blue New England Options v.4. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year.
For help in finding the benefits tier of a provider, visit the online provider search tool at **www.bluecrossma.com/findadoctor** and search for HMO Blue New England Options v.4.

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✔ 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

Within the HMO Blue New England Options network, hospitals and groups of primary care providers (PCPs) are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield. **Where you receive care will determine your out-of-pocket costs for most services under the plan.** By choosing Enhanced Benefits Tier providers each time you get hospital or PCP care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.
- **Standard Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and are moderate cost relative to our benchmark and hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.
- **Basic Benefits Tier**—Includes Massachusetts hospitals that are high cost relative to our benchmark and PCPs that do not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pockets costs when you choose providers in the Basic Benefits Tier.

Note: PCPs were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Providers without sufficient data for either cost or quality are placed in the Standard Benefits Tier. Providers that do not meet benchmarks for one or both of the domains and hospitals that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your primary care provider and the facility where your provider has admitting privileges before you choose a PCP or receive care. For example, if you require hospital care and your Enhanced Benefits Tier PCP refers you to an Enhanced Benefits Tier hospital, you would pay the lowest cost sharing for both your PCP and hospital services. Or, if your Enhanced Benefits Tier PCP refers you to a Basic Benefits Tier hospital for care, you will pay the lowest copayments for PCP services, but the highest copayments for hospital services, except in an emergency.

Copayments Outside of Massachusetts.

For network providers outside of Massachusetts, a network provider who is listed as a general practitioner, internist, family practitioner, pediatrician, obstetrician/gynecologist, nurse practitioner, rural health center, or general hospital is considered an Enhanced Benefits Tier provider. Other providers in our New England network carry the higher, specialist copayment.

Your Primary Care Provider.

When you enroll in Network Blue New England, 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.

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). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is probably someone affiliated with your PCP's hospital or medical group. You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield concerning referrals, and 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 and services requiring referral from your PCP are detailed in your benefit description.

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 deductibles are:

Enhanced Tier: None

Standard and Basic Tiers combined: $250 per member (or **$750** per family)

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$2,500** per member (or **$5,000** per family) for all tiers combined. Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

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. Any additional follow-up care must be arranged by your PCP. Please see your benefit description for more information.

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 **$100** copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. There is no deductible for these services. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital. Any follow-up care must be arranged by your PCP.

Dependent Benefits.

This plan covers dependents until 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 benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics	Your Cost for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
Plan-year deductible	None	$250 per member/$750 per family for Standard and Basic Benefits combined	
Plan-year out-of-pocket maximum	$2,500 per member/$5,000 per family for all tiers combined		
Covered Services			
Preventive Care Well-child care exams, including routine tests and immunizations	Nothing	Nothing	Nothing
Preventive dental care for children under age 12 (one visit each six months)	Nothing	Nothing	Nothing
Routine adult physical exams, including routine tests and immunizations	Nothing	Nothing	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	Nothing	Nothing
Routine hearing exams, including routine tests	Nothing	Nothing	Nothing
Routine vision exam (one every 24 months)	Nothing	Nothing	Nothing
Family planning services–office visits	Nothing	Nothing	Nothing
Hearing Benefits Routine hearing exams, including routine tests	Nothing	Nothing	Nothing
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum	All charges beyond the benefit maximum	All charges beyond the benefit maximum
Other Outpatient Care Emergency room visits	$100 per visit (waived if admitted or for observation stay)	$100 per visit (waived if admitted or for observation stay)	$100 per visit (waived if admitted or for observation stay)
Office visits • PCP, network nurse practitioner, or nurse midwife (billed by PCP) • Network nurse practitioner or nurse midwife (not billed by PCP) • Other network providers	 $20 per visit $15 per visit $35 per visit	 $20 per visit $15 per visit $35 per visit	 $20 per visit $15 per visit $35 per visit
Mental health and substance abuse treatment	$15 per visit	$15 per visit	$15 per visit
Chiropractors' office visits	$20 per visit	$20 per visit	$20 per visit
Short-term rehabilitation therapy–physical, occupational, and speech (up to 60 visits per calendar year*)	$20 per visit for visits 1-30 $35 per visit for visits 31-60	$20 per visit for visits 1-30 $35 per visit for visits 31-60	$20 per visit for visits 1-30 $35 per visit for visits 31-60
Home health care and hospice services	Nothing	Nothing	Nothing
Oxygen and equipment for its administration	Nothing	Nothing	Nothing
Prosthetic devices	20% coinsurance	20% coinsurance	20% coinsurance
Durable medical equipment–such as wheelchairs, crutches, and hospital beds	20% coinsurance**	20% coinsurance**	20% coinsurance**
Surgery and related anesthesia • Office setting: PCP/Other network providers • Surgical day care unit • Ambulatory surgical facility	 $20 per visit***/$35 per visit*** $150 per admission $150 per admission	 $20 per visit***/$35 per visit*** $150 per admission after deductible $200 per admission at selected hospitals† $150 per admission	 $20 per visit***/$35 per visit*** $150 per admission after deductible $150 per admission
Diagnostic X-rays, lab tests, and other tests • General hospitals • Other covered providers	 Nothing Nothing	 Nothing after deductible† Nothing	 Nothing after deductible Nothing
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests†† • General hospitals • Other covered providers	 $50 per category per date of service $50 per category per date of service	 $50 per category per date of service after deductible† $50 per category per date of service	 $100 per category per date of service after deductible $50 per category per date of service
Inpatient Care (including maternity care) General hospital care (as many days as medically necessary)	$300 per admission	$300 per admission after deductible†	$700 per admission after deductible
Chronic disease hospital care (as many days as medically necessary)	$150 per admission	$150 per admission	$150 per admission
Mental hospital or substance abuse facility care (as many days as medically necessary)	$150 per admission	$150 per admission	$150 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	Nothing	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	Nothing	Nothing

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

** 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.

† The selected Standard Benefits Tier hospitals noted in this chart include Athol Memorial Hospital, Baystate Franklin Medical Center, Baystate Mary Lane Hospital, Berkshire Medical Center, Falmouth Hospital, Martha's Vineyard Hospital, and Nantucket Cottage Hospital. The deductible does not apply for any covered services furnished by these hospitals.

†† In Connecticut, when the copayments for CT scans, MRIs, PET scans, and/or nuclear cardiac imaging tests add up to the total of $375 per member in a calendar year, you pay nothing for these tests for the remainder of that calendar year.

Prescription Drug Benefits	Your Cost for Enhanced Benefits Tier Network Providers*	Your Cost for Standard Benefits Tier Network Providers*	Your Cost for Basic Benefits Tier Network Providers*
Plan-year out-of-pocket maximum	$1,000 per member/$2,000 per family for all tiers combined		
At retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1** $25 for Tier 2 $50 for Tier 3	No deductible $10 for Tier 1** $25 for Tier 2 $50 for Tier 3	No deductible $10 for Tier 1** $25 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)	$20 for Tier 1** $50 for Tier 2 $110 for Tier 3	No deductible $20 for Tier 1** $50 for Tier 2 $110 for Tier 3	No deductible $20 for Tier 1** $50 for Tier 2 $110 for Tier 3

* Cost share waived for certain orally-administered anticancer drugs.

** Cost share waived for birth control.

Get the Most from Your Plan.

Visit us at **www.bluecrossma.com/membercentral** or call **1-800-782-3675** to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program 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 benefit description for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program 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 benefit description for details.)	$150 per calendar year per policy
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 1-800-782-3675.

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 benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.
Please note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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