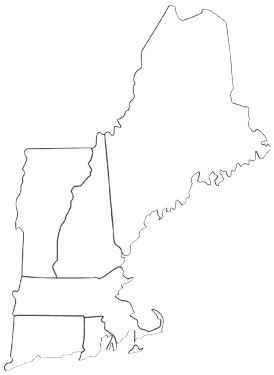
BlueCross® BlueShield®

SUMMARY OF BENEFITS

HMO Blue New England℠ $1,500 Deductible

Plan-Year Deductible: $1,500/$3,000

Winn Companies



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

Your Care

Your Primary Care Provider (PCP)

When you enroll in HMO Blue New England, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the Provider Directory; or call the Physician Selection Service at **1-800-821-1388.**

If you have trouble choosing a doctor, the Physician Selection Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely 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 of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see 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 of Massachusetts. Your deductible is **$1,500** per member (or **$3,000** 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 (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is **$6,350** per member (or **$12,700** per family).

Emergency Care

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 copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart on the opposite page for your cost share amount.

Telehealth Services

You are covered for certain medical and behavioral health services for conditions that can be treated through video visits from an approved Telehealth provider. These Telehealth services are available by using your computer or mobile device when you prefer not to make an in-person visit for any reason to a doctor or therapist. For a list of Telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the Provider Directory; or call the Physician Selection Service at **1-800-821-1388.**

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, you should 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. See your subscriber certificate for more information.

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. See your subscriber certificate (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	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
Outpatient Care Emergency room visits	$200 per visit, no deductible (waived if admitted or for observation stay)
Office visits, when performed by: • Your PCP, OB/GYN physician, network nurse practitioner or nurse midwife • Other network providers	 $25 per visit, no deductible $40 per visit, no deductible
Chiropractors' office visits*	$40 per visit, no deductible
Mental health or substance abuse treatment	$25 per visit, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year**)	$40 per visit after deductible
Speech, hearing, and language disorder treatment–speech therapy	$40 per visit after deductible
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
Home health care and hospice services	Nothing, no deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible***
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office, when performed by: • Your PCP or OB/GYN physician • Other network providers	 $25 per visit†, no deductible $40 per visit†, no deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	Nothing after deductible
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	Nothing, no 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

* For a network chiropractor in Maine, you pay $25 per visit.

** 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)	No deductible
• Covered smoking cessation drugs***	Nothing for Tier 1 Nothing for Tier 2 Nothing for Tier 3 $120 for Tier 4
• All other covered drugs and supplies	$15 for Tier 1† $30 for Tier 2 $60 for Tier 3 $120 for Tier 4
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible
• Covered smoking cessation drugs***	Nothing for Tier 1 Nothing for Tier 2 Nothing for Tier 3 $360 for Tier 4
• 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 for Tier 1 $30 for Tier 2 $60 for Tier 3 $360 for Tier 4
• All other covered drugs and supplies	$30 for Tier 1† $60 for Tier 2 $120 for Tier 3 $360 for Tier 4

* Tier 1 generally refers to generic drugs; Tier 2 generally refers to preferred drugs; Tier 3 refers to non-preferred drugs. Your pharmacy coverage includes the Select Home Delivery Program. Under this program, when you buy certain approved maintenance drugs from a covered retail pharmacy, coverage is provided for only two refills of that drug within a 365-day period. In order to receive coverage for more refills of that drug from a covered retail pharmacy, you will be asked to decide whether you want to continue to receive your drug refills from the retail pharmacy or whether you will receive your drug refills from the covered mail service pharmacy. After you buy your first fill of the listed drug from the retail pharmacy, you will receive a letter from Blue Cross Blue Shield of Massachusetts that will tell you how to make your selection. If you do not make a selection before you buy a third refill, the covered mail service pharmacy will automatically qualify as your choice. No retail pharmacy coverage will be provided for more than two refills of the same drug unless you have chosen the retail pharmacy option. To find out which maintenance drugs are on the Select Home Delivery Pharmacy Drug list, call the Member Service toll-free number on your ID card, or visit our website at **www.bluecrossma.com** and click on Medication Look Up.** Cost share waived for certain orally-administered anticancer drugs.

*** For a list of these drugs, contact Blue Cross and Blue Shield of Massachusetts or visit the Value-Based Benefits page in the Pharmacy Coverage section at **www.bluecrossma.com**.

† 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 available to you, like those listed below.

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 subscriber certificate 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 subscriber certificate 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?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-800-782-3675,** or visit us online at **www.bluecrossma.com**. Interested in receiving information from us 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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