

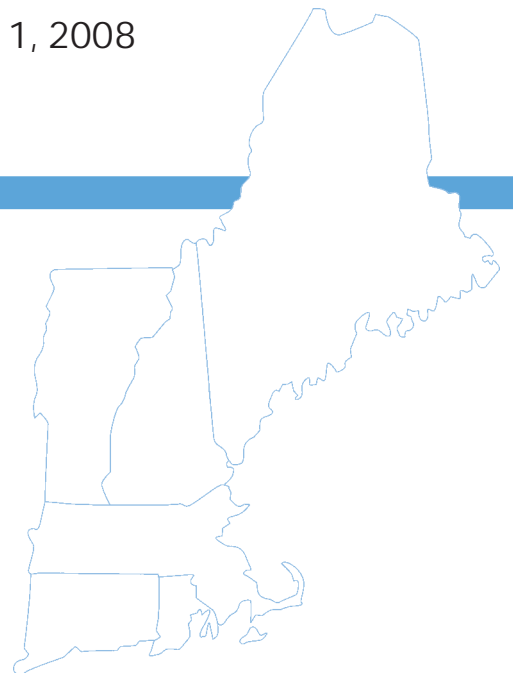


HMO Blue[®] New England Enhanced Value

Summary of Benefits

Effective on anniversary dates on or after January 1, 2008

This Health Plan meets Minimum Creditable Coverage Standards which are effective January 1, 2009, as part of Massachusetts Health Care Reform Law.



Your Care

Your Primary Care Physician.

When you join HMO Blue New England Enhanced Value, you must choose a primary care physician (PCP) for you and each member of your family from any New England state. There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the *HMO Blue New England 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. The specialist will usually be one your PCP knows, probably someone affiliated with your PCP's hospital or medical group. 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.

Out-of-Pocket Maximum for Certain Copayments.

You're protected by an out-of-pocket maximum of **\$2,000** for each member in a calendar year (or **\$4,000** per family). Only copayments for inpatient admissions, outpatient day surgical admissions, and emergency room visits will be applied to this 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). There is a **\$75** copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay.

HMO Blue New England 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. Please see your subscriber certificate for a complete definition of the service area.

When Outside the HMO Blue New England 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 to age 26, or for two calendar years after the dependent is no longer claimed on the subscriber's or spouse's federal tax return, 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	\$75 per visit (waived if admitted or for observation stay)
Well-child care visits	\$20 per visit (no cost for immunizations and routine tests)
Routine adult physical exams (including related tests)	\$20 per visit (no cost for routine tests)
Routine GYN exams, including related lab tests (one per calendar year)	\$20 per visit (no cost for routine tests)
Routine hearing exams	\$20 per visit
Routine vision exams (one every 24 months)	\$20 per visit
Family planning services—office visits	\$20 per visit
Office visits	\$20 per visit
Chiropractor services	\$20 per visit
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$20 per visit
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit
Allergy injections only	Nothing
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, and PET scans	Nothing
CT scans, MRIs, and PET scans	\$50 per category per date of service**
Home health care, including hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Prosthetic devices and repairs	Nothing
Durable medical equipment and repairs—such as wheelchairs, crutches, hospital beds (up to \$750 per calendar year***)	All charges beyond the calendar-year benefit maximum
Surgery and related anesthesia	Nothing
• Office setting	\$250 per admission†
• Ambulatory surgical facility, hospital, or surgical day care unit	
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission†
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 \$100 for Tier 3

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

** When the copayments for CT scans, MRIs, and/or PET scans 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.

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

† Copayments for consecutive inpatient admissions (or day surgery followed by inpatient care) within 30 days for the same or related illness will not exceed \$500.

Your Medical Benefits (continued)

Covered Services	Your Cost
Mental Health and Substance Abuse Treatment Biologically based conditions* Inpatient admissions in a general hospital or mental hospital	\$500 per admission**
Outpatient visits	\$20 per visit
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	\$500 per admission**
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	\$500 per admission**
Outpatient visits (up to 24 visits per calendar year)	\$20 per visit
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	\$500 per admission**
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	\$500 per admission**
Outpatient visits (up to 8 visits per calendar year***)	\$20 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.

** Copayments for consecutive inpatient admissions (or day surgery followed by inpatient care) within 30 days for the same or related illness will not exceed \$500.

*** 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 Healthy Blue, 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 our *Healthy Blue* booklet, which outlines these special programs.

LIVING HEALTHY <i>Babies</i> ®	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
Discounts on safety helmets and home safety items	Discount varies
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
Blue Care® Line to answer your health care questions 24 hours a day—call 1-888-247-BLUE (2583)	No charge
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.

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.