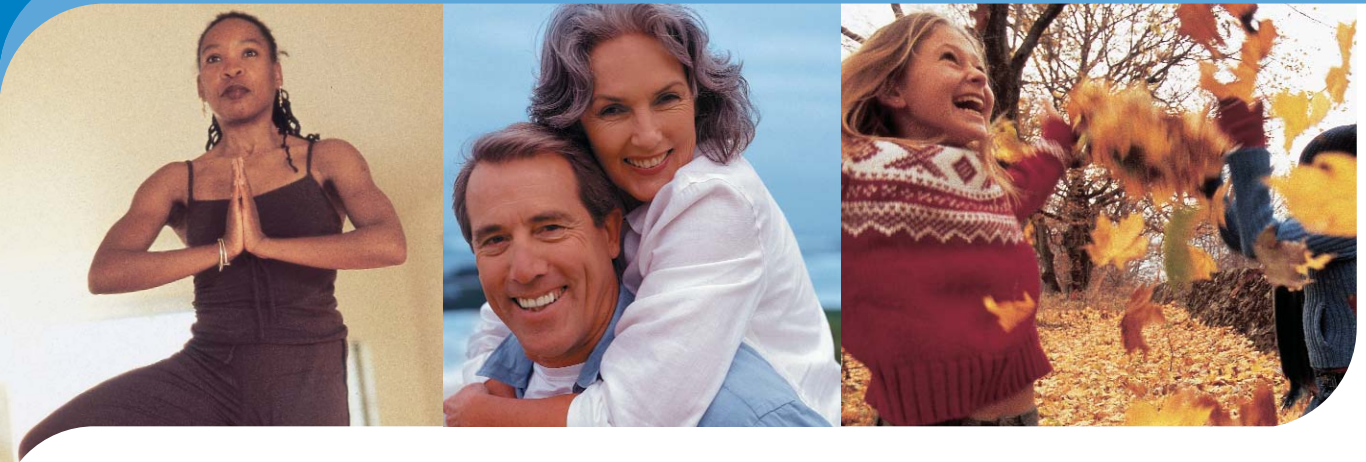




MASSACHUSETTS



Blue Choice[®] Plan 2

Summary of Benefits

City of Gardner

✓ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that will be effective January 1, 2009, as part of the Massachusetts Health Care Reform Law.

Your Care

Your Primary Care Physician.

When you join Blue Choice, you choose a primary care physician (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.

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 benefit description.

When You Choose to Receive Care on Your Own.

Your health care plan also allows you to seek most care without a PCP referral, at a lower level of coverage. You may choose any licensed health care provider. When you choose to seek care on your own, some responsibility is yours. If you require hospitalization, you, or someone on your behalf, will need to call us before you're admitted (or within 48 hours of an emergency or maternity admission) to make sure that you're covered.

You may have additional out-of-pocket expenses when you seek care without a referral from your PCP. These expenses include the following:

- For self-referred services, you must pay a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. The deductible is **\$250** for each member (or **\$500** per family). After you have met your deductible, you pay **20 percent** co-insurance for covered services.

Covered charges for any services you receive during October, November, and December that are applied toward your deductible, will also be applied toward your deductible for the next calendar year.

- When the money you've paid for your 20 percent co-insurance equals **\$1,000** for each member in a calendar year (or **\$2,000** per family), then your benefits (or your family's benefits) are provided in full, based on the allowed charge, up to any benefit maximums, for the rest of that calendar year. Your PCP/plan-approved copayments do not count toward your co-insurance maximum. You must still pay your copayment when it applies.
- For services not approved as PCP/plan-approved benefits, your health care plan provides up to a lifetime maximum benefit of **\$1,000,000** for each member.

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 **\$25** copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts. Please see your benefit description for exact service area details.

When Outside the Service Area.

If you're traveling outside the plan's 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. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

Dependent and Student Benefits.

This health care plan covers your unmarried dependent children until age 19, or full-time students until age 25. Coverage ends when the student turns 25, or marries, or on November 1 following the date the student discontinues full-time classes or graduates, whichever comes first.

Your Medical Benefits

Covered Services	Your Cost For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Major Medical Benefits (after your deductible)
Outpatient Care		
Emergency room visits	\$25 per visit (waived if admitted or for observation stay)	\$25 per visit (waived if admitted or for observation stay)
Well-child care visits	\$10 per visit (no cost for immunizations and routine tests)	20% co-insurance* (through age 5**)
Routine adult physical exams, including related tests	\$10 per visit (no cost for routine tests)	Not covered
Routine GYN exams, including related lab tests (one per calendar year)	\$10 per visit (no cost for routine tests)	Not covered
Routine hearing exams	\$10 per visit	Not covered
Routine vision exams (one per calendar year)	\$10 per visit	Not covered
Family planning services—office visits	\$10 per visit	20% co-insurance*
Office visits	\$10 per visit	20% co-insurance*
Chiropractor services	Not covered	20% co-insurance*
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year***)	\$10 per visit	20% co-insurance*
Speech, hearing, and language disorder treatment—speech therapy	\$10 per visit	20% co-insurance*
Allergy injections only	Nothing	20% co-insurance*
Diagnostic X-rays, lab tests, and other tests	Nothing	20% co-insurance*
Home health care	Nothing	20% co-insurance*
Hospice services	Nothing	Not covered
Oxygen and equipment for its administration	Nothing	20% co-insurance*
Durable medical equipment—such as wheelchairs, crutches, hospital beds (up to \$1,500 per calendar year†)	All charges beyond the calendar-year benefit maximum	20% co-insurance* and all charges beyond the calendar-year benefit maximum
Prosthetic devices	20% co-insurance	20% co-insurance*
Surgery and related anesthesia <ul style="list-style-type: none"> • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit 	\$10 per visit Nothing	20% co-insurance* 20% co-insurance*
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	Nothing	20% co-insurance*
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% co-insurance*
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% co-insurance*
Prescription Drug Benefits		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	\$5 for Tier 1 \$10 for Tier 2 \$25 for Tier 3	
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	\$5 for Tier 1 \$10 for Tier 2 \$25 for Tier 3	

* In addition to your deductible and 20% co-insurance, you may be responsible for any balance of charges above the allowed charge for providers who do not have payment agreements with Blue Cross and/or Blue Shield.

** This service is provided according to an age-based schedule.

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

† No dollar limit 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 For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Major Medical Benefits (after your deductible)
Mental Health and Substance Abuse Treatment		
Biologically based conditions*		
Inpatient admissions in a general hospital or mental hospital	Nothing	Not covered
Outpatient visits	\$10 per visit	Not covered
Non-biologically based mental conditions (includes drug addiction and alcoholism)		
Inpatient admissions in a general hospital	Nothing	Not covered
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing	Not covered
Outpatient visits (up to 24 visits per calendar year)	\$10 per visit	Not covered
Alcoholism treatment (in addition to non-biologically based mental conditions)		
Inpatient admissions in a general hospital	Nothing	Not covered
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing	Not covered
Outpatient visits (up to 8 visits per calendar year)	\$10 per visit	Not covered

* 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.

** In addition to your deductible and 20% co-insurance, you may be responsible for any balance of charges above the allowed charge for providers who do not have payment agreements with Blue Cross and/or Blue Shield.

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 **1-800-932-8323** to receive our

Healthy Blue booklet, which outlines these special programs.

Living Healthy Babies®	No charge
A Fitness Benefit toward membership at a health club (see your benefit description 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 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 1-800-932-8323.

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; hearing aids; 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.

