

Schedule of Benefits

Access Blue New England

Saver

This is the *Schedule of Benefits* that is a part of your Subscriber Certificate. This chart describes the cost share amounts that you will have to pay for *covered services*. It also shows the *benefit limits* that apply for *covered services*. Do not rely on this chart alone. **Be sure to read all parts of your Subscriber Certificate to understand the requirements you must follow to receive all of your coverage. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for this coverage.** All words that show in italics are explained in Part 2. **To receive coverage, you must obtain your health care services and supplies from *covered providers* who participate in your health plan's provider network.** Also, for some health care services, you may have to have an approved referral from your *primary care provider* or approval from your health plan in order for you to receive coverage from your health plan. These requirements are fully outlined in Part 4. If a referral or an approval is required, you should make sure that you have it before you receive your health care service. Otherwise, you may have to pay all costs for the health care service.

Your health plan's provider network is **HMO Blue New England**. The *service area* where your *covered services* will be furnished includes all counties in Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, and Vermont. See Part 1 for information about how to find a provider in your health care network.

The following definitions will help you understand your cost share amounts and how they are calculated.

- A ***deductible*** is the cost you may have to pay for certain *covered services* you receive during your annual coverage period before benefits are paid by the health plan. This chart shows the dollar amount of your *deductible* and the *covered services* for which you must first pay the *deductible*.
- A ***copayment*** is the fixed dollar amount you may have to pay for a *covered service*, usually when you receive the *covered service*. This chart shows the times when you will have to pay a *copayment*.
- A ***coinsurance*** is the percentage (for example, 20%) you may have to pay for a *covered service*. This chart shows the times, if there are any, when you will have to pay *coinsurance*.

Your cost share will be calculated based on the *allowed charge* or the provider's actual charge if it is less than the *allowed charge*. You will not have to pay charges that are more than the *allowed charge* when you use a *covered provider* who participates in your health care network to furnish *covered services*.

IMPORTANT NOTE: The provisions described in this *Schedule of Benefits* may change. If this happens, the change is described in a *rider*. Be sure to read each *rider* (if there are any) that applies to your coverage in this health plan to see if it changes this *Schedule of Benefits*.

The explanation of any special provisions as noted by an asterisk can be found after this chart.

Overall Member Cost Share Provisions	
<p>Deductible</p> <p>Your <i>deductible</i> per plan year is:</p> <p>This <i>deductible</i> applies to all <i>covered services</i> <u>except</u> preventive health services (other than hearing aids and related <i>covered services</i>) and certain <i>covered services</i> as noted in this chart.</p>	<p>The <i>deductible</i> is the cost you have to pay for certain <i>covered services</i> during your annual coverage period before benefits will be paid for those <i>covered services</i>.</p> <p>\$1,650 per individual plan \$3,300 per family plan</p> <p>The family <i>deductible</i> can be met by eligible costs incurred by any combination of <i>members</i> enrolled under the same family plan. But, the entire amount of the family <i>deductible</i> must be met before benefits will be provided for any one <i>member</i>.</p>
<p>Out-of-Pocket Maximum</p> <p>Your <i>out-of-pocket maximum</i> per plan year is:</p> <p>This <i>out-of-pocket maximum</i> is a total of the <i>deductible</i>, <i>copayments</i>, and <i>coinsurance</i> you pay for <i>covered services</i>.</p>	<p>The <i>out-of-pocket maximum</i> is the most you could pay during your annual coverage period for your share of the costs for <i>covered services</i>.</p> <p>\$6,450 per individual plan \$12,900 per family plan, but no more than \$6,450 per <i>member</i></p> <p>The family <i>out-of-pocket maximum</i> can be met by eligible costs incurred by any combination of <i>members</i> enrolled under the same family plan. But, no one <i>member</i> will have to pay more than the per <i>member out-of-pocket maximum</i>.</p>
Overall Benefit Maximum	None
Covered Services	Your Cost Is:
<p>Admissions for Inpatient Medical and Surgical Care</p>	<ul style="list-style-type: none"> • In a General Hospital <u>Hospital services</u> No charge after <i>deductible</i>
	<ul style="list-style-type: none"> • In a General Hospital <u>Physician and other covered professional provider services</u> No charge after <i>deductible</i>
	<ul style="list-style-type: none"> • In a Chronic Disease Hospital (same as admissions in a General Hospital)
	<ul style="list-style-type: none"> • In a Rehabilitation Hospital (60-day <i>benefit limit</i> per <i>member</i> per calendar year) <u>Hospital services</u> No charge after <i>deductible</i>
	<ul style="list-style-type: none"> • In a Rehabilitation Hospital (60-day <i>benefit limit</i> per <i>member</i> per calendar year) <u>Physician and other covered professional provider services</u> No charge after <i>deductible</i>

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		Your Cost Is:
Admissions for Inpatient Medical and Surgical Care (continued)	<ul style="list-style-type: none"> In a Skilled Nursing Facility (100-day <i>benefit limit</i> per member per calendar year) 	
	<ul style="list-style-type: none"> <u>Facility services</u> 	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> <u>Physician and other covered professional provider services</u> 	No charge after <i>deductible</i>
Ambulance Services (ground or air ambulance transport)	<ul style="list-style-type: none"> Emergency ambulance 	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> Other ambulance 	No charge after <i>deductible</i>
Cardiac Rehabilitation	<i>Outpatient</i> services	\$25 <i>copayment</i> per visit after <i>deductible</i>
Chiropractor Services (for <i>members</i> of any age)	<ul style="list-style-type: none"> <i>Outpatient</i> lab tests and x-rays 	See Lab Tests, X-Rays, and Other Tests
	<ul style="list-style-type: none"> <i>Outpatient</i> medical care services, including spinal manipulation (a <i>benefit limit</i> does not apply) 	\$25 <i>copayment</i> per visit after <i>deductible</i>
Dialysis Services	<i>Outpatient</i> services and home dialysis	No charge after <i>deductible</i>
Durable Medical Equipment	<ul style="list-style-type: none"> Covered medical equipment rented or purchased for home use 	20% after <i>deductible</i>
	<ul style="list-style-type: none"> One breast pump per birth (rented or purchased), including related parts and supplies 	No charge (<i>deductible</i> does not apply)
		No coverage is provided for hospital-grade breast pumps.
Early Intervention Services	<i>Outpatient</i> intervention services for eligible child from birth through age two	No charge after <i>deductible</i>
Emergency Medical Outpatient Services	<ul style="list-style-type: none"> Emergency room services 	\$150 <i>copayment</i> per visit after <i>deductible</i> ; <i>copayment</i> waived if held for observation or admitted within 24 hours
	<ul style="list-style-type: none"> Hospital outpatient department services 	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> Office, health center, and home services <p><u>by your <i>primary care provider</i>; or by an OB/GYN physician or nurse midwife; or by a physician assistant or nurse practitioner designated by the health plan as <i>primary care</i></u></p>	\$15 <i>copayment</i> per visit after <i>deductible</i>

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		Your Cost Is:
Emergency Medical Outpatient Services (continued)	<ul style="list-style-type: none"> Office, health center, and home services <u>by a network specialist or other covered provider (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care</u> 	\$25 copayment per visit after deductible
Home Health Care	Home care program	No charge after deductible
Hospice Services	Inpatient or outpatient hospice services for terminally ill	No charge after deductible
Infertility Services	<ul style="list-style-type: none"> Inpatient services 	See Admissions for Inpatient Medical and Surgical Care
	<ul style="list-style-type: none"> Outpatient surgical services 	See Surgery as an Outpatient
	<ul style="list-style-type: none"> Outpatient lab tests and x-rays 	See Lab Tests, X-Rays, and Other Tests
	<ul style="list-style-type: none"> Outpatient medical care services 	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	<ul style="list-style-type: none"> Outpatient lab tests <u>by a general hospital</u> 	No charge after deductible
	<ul style="list-style-type: none"> <u>by other covered providers</u> 	No charge after deductible
	<ul style="list-style-type: none"> Outpatient x-rays and other imaging tests (other than advanced imaging tests) <u>by a general hospital</u> 	No charge after deductible
	<ul style="list-style-type: none"> <u>by other covered providers</u> 	No charge after deductible
	<ul style="list-style-type: none"> Outpatient advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging) <u>by a general hospital</u> 	No charge after deductible
	<ul style="list-style-type: none"> <u>by other covered providers</u> 	No charge after deductible
	<ul style="list-style-type: none"> Other outpatient tests and preoperative tests <u>by a general hospital</u> 	No charge after deductible
	<ul style="list-style-type: none"> <u>by other covered providers</u> 	No charge after deductible

This chart shows your cost share for covered services. You must pay all charges in excess of a benefit limit.

Covered Services		Your Cost Is:
Maternity Services and Well Newborn Care (includes \$90/\$45 for childbirth classes; deductible does not apply)	<ul style="list-style-type: none"> Maternity services <u>Facility services</u> (inpatient and outpatient covered services) 	No charge after deductible
	<ul style="list-style-type: none"> <u>Physician and other covered professional provider services</u> (includes delivery and postnatal care) 	No charge after deductible
	<ul style="list-style-type: none"> Prenatal care 	No charge (deductible does not apply)
	<ul style="list-style-type: none"> Well newborn care during covered maternity admission 	No charge (deductible does not apply)
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	<ul style="list-style-type: none"> Office, health center, and home medical services <u>by your primary care provider; or by an OB/GYN physician, nurse midwife, or limited services clinic; or by a physician assistant or nurse practitioner designated by the health plan as primary care</u> 	\$15 copayment per visit after deductible
	<ul style="list-style-type: none"> <u>by a network specialist or other covered provider (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care</u> 	\$25 copayment per visit after deductible, except lower copayment applies for infertility treatment
	<ul style="list-style-type: none"> Hospital outpatient medical services 	No charge after deductible
	<ul style="list-style-type: none"> Acupuncture services (12-visit benefit limit per member per calendar year) 	\$25 copayment per visit after deductible
Medical Formulas	Certain medical formulas and low protein foods	No charge after deductible

This chart shows your cost share for covered services. You must pay all charges in excess of a benefit limit.

Covered Services		Your Cost Is:
Mental Health and Substance Use Treatment	<ul style="list-style-type: none"> Inpatient admissions in a General Hospital <p><u>Hospital services</u></p>	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> Physician and other covered professional provider services <p><u>Physician and other covered professional provider services</u></p>	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> Inpatient admissions in a Mental Hospital or Substance Use Facility <p><u>Facility services</u></p>	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> Physician and other covered professional provider services <p><u>Physician and other covered professional provider services</u></p>	No charge after <i>deductible</i>
Oxygen and Respiratory Therapy	<ul style="list-style-type: none"> Oxygen and equipment for its administration 	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> Outpatient respiratory therapy 	No charge after <i>deductible</i>
Podiatry Care	<ul style="list-style-type: none"> Outpatient lab tests and x-rays 	See Lab Tests, X-Rays, and Other Tests
	<ul style="list-style-type: none"> Outpatient surgical services 	See Surgery as an Outpatient
	<ul style="list-style-type: none"> Outpatient medical care services 	See Medical Care Outpatient Visits
Prescription Drugs and Supplies Drug Formulary (includes syringes and needles)	<ul style="list-style-type: none"> Retail Pharmacy (30-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	\$10 <i>copayment</i> after <i>deductible</i> \$25 <i>copayment</i> after <i>deductible</i> \$45 <i>copayment</i> after <i>deductible</i> This cost share is waived for Tier 1 birth control drugs and devices; and certain preventive drugs as required by federal law. For insulin infusion pumps and certain orally-administered anticancer drugs, you pay only the <i>deductible</i> .
	<ul style="list-style-type: none"> Mail Order Pharmacy (90-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	\$20 <i>copayment</i> after <i>deductible</i> \$50 <i>copayment</i> after <i>deductible</i> \$135 <i>copayment</i> after <i>deductible</i> This cost share is waived for Tier 1 birth control drugs and devices; and certain preventive drugs as required by federal law. For certain orally-administered anticancer drugs, you pay only the <i>deductible</i> .

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services	Your Cost Is:	
Preventive Health Services	<ul style="list-style-type: none"> • Routine pediatric care <u>Routine medical exams and immunizations</u> 	No charge
	<ul style="list-style-type: none"> <u>Routine tests</u> 	No charge
	<ul style="list-style-type: none"> <u>Annual mental health wellness exams</u> 	These <i>covered services</i> include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.
	<ul style="list-style-type: none"> • Preventive dental care for <i>members</i> under age 18 for treatment of cleft lip/cleft palate 	No charge
	<ul style="list-style-type: none"> • Routine adult care 	No charge
	<ul style="list-style-type: none"> <u>Routine medical exams and immunizations</u> 	No charge
	<ul style="list-style-type: none"> <u>Routine tests</u> 	No charge
	<ul style="list-style-type: none"> <u>Annual mental health wellness exams</u> 	These <i>covered services</i> include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; routine mammograms; blood tests to screen for lead poisoning; and routine colonoscopies.
	<ul style="list-style-type: none"> • Routine GYN care 	No charge
	<ul style="list-style-type: none"> <u>Routine GYN exams</u> (one exam per <i>member</i> per calendar year) 	No charge
<ul style="list-style-type: none"> <u>Routine Pap smear tests</u> (one test per <i>member</i> per calendar year) 	No charge	
<ul style="list-style-type: none"> • Family planning 	No charge	
<ul style="list-style-type: none"> • Routine hearing care 	No charge	
<ul style="list-style-type: none"> <u>Routine hearing exams/tests</u> 	No charge	
<ul style="list-style-type: none"> <u>Newborn hearing screening tests</u> 	No charge	
<ul style="list-style-type: none"> <u>Hearing aids/related services</u> for <i>members</i> age 21 or younger (\$2,000 for one hearing aid per hearing-impaired ear every 36 months) 	No charge after <i>deductible</i>	

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		Your Cost Is:
Preventive Health Services (continued)	<ul style="list-style-type: none"> Routine vision care <u>Routine vision exams</u> (one exam per <i>member</i> every 24 months) 	No charge
	<ul style="list-style-type: none"> <u>Vision supplies/related services</u> 	Not covered; you pay all charges
Prosthetic Devices	<ul style="list-style-type: none"> Ostomy supplies 	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> Artificial limb devices (includes repairs) and other external prosthetic devices 	20% after <i>deductible</i>
Radiation Therapy and Chemotherapy	<i>Outpatient</i> services	No charge after <i>deductible</i>
Second Opinions	<i>Outpatient</i> second and third opinions	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy) Includes habilitation services	<i>Outpatient</i> services (60-visit <i>benefit limit</i> per <i>member</i> per calendar year for physical and occupational therapy, except for autism; a <i>benefit limit</i> does not apply for speech therapy)	\$25 <i>copayment</i> per visit after <i>deductible</i>
Speech, Hearing, and Language Disorder Treatment	<ul style="list-style-type: none"> <i>Outpatient</i> diagnostic tests 	See Lab Tests, X-Rays, and Other Tests
	<ul style="list-style-type: none"> <i>Outpatient</i> speech therapy 	See Short-Term Rehabilitation Therapy
	<ul style="list-style-type: none"> <i>Outpatient</i> medical care services 	See Medical Care Outpatient Visits
Surgery as an Outpatient (excludes removal of impacted teeth whether or not the teeth are imbedded in the bone)	<ul style="list-style-type: none"> <i>Outpatient</i> day surgery <u>Hospital surgical day care unit or outpatient department services</u> 	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> <u>Ambulatory surgical facility services</u> 	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> <u>Physician and other covered professional provider services</u> 	No charge after <i>deductible</i>
	<ul style="list-style-type: none"> Sterilization procedure for a female <i>member</i> when performed as the primary procedure for family planning reasons 	No charge (<i>deductible</i> does not apply)

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		Your Cost Is:
Surgery as an Outpatient (continued)	<ul style="list-style-type: none"> Office and health center surgical services by your <i>primary care provider</i>; or by an <u>OB/GYN physician or nurse midwife</u>; or by a <u>physician assistant or nurse practitioner designated by the health plan as primary care</u> 	\$15 <i>copayment</i> per visit after <i>deductible</i>
	<ul style="list-style-type: none"> by a network specialist or <u>other covered provider (non-hospital)</u>, including a <u>physician assistant or nurse practitioner designated by the health plan as specialty care</u> 	\$25 <i>copayment</i> per visit after <i>deductible</i> , except lower <i>copayment</i> applies for infertility treatment
TMJ Disorder Treatment	<ul style="list-style-type: none"> <i>Outpatient</i> x-rays 	See Lab Tests, X-Rays, and Other Tests
	<ul style="list-style-type: none"> <i>Outpatient</i> surgical services 	See Surgery as an Outpatient
	<ul style="list-style-type: none"> <i>Outpatient</i> physical therapy 	See Short-Term Rehabilitation Therapy
	<ul style="list-style-type: none"> <i>Outpatient</i> medical care services 	See Medical Care Outpatient Visits

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.