Schedule of Benefits

HMO Blue New England

Deductible

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	
Deductible Your *deductible* per *plan year* is: This *deductible* applies to all *covered services* except preventive health services, prescription drugs and supplies, and certain *covered services* as noted in this chart.	The *deductible* is the cost you have to pay for certain *covered services* during your annual coverage period before benefits will be paid for those *covered services*. $1,000 per *member* $2,000 per family The family *deductible* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member deductible*.
Out-of-Pocket Maximum Your *out-of-pocket maximum* per *plan year* is: This *out-of-pocket maximum* is a total of the *deductible*, *copayments*, and *coinsurance* you pay for *covered services*.	The *out-of-pocket maximum* is the most you could pay during your annual coverage period for your share of the costs for *covered services*. $5,450 per *member* $10,900 per family The amounts shown above exclude cost share you pay for your prescription drug benefits. And a separate *out-of-pocket maximum* for your prescription drug benefits: $1,000 per *member* $2,000 per family The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.
Overall Benefit Maximum	None

Covered Services		Your Cost Is:
Admissions for Inpatient Medical and Surgical Care	• In a General Hospital	
	Hospital services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*
	• In a Chronic Disease Hospital	(same as admissions in a General Hospital)
	• In a Rehabilitation Hospital (60-day *benefit limit* per *member* per calendar year)	
	Hospital services	No charge after *deductible*
	Physician and other covered professional provider services	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:
Admissions for Inpatient Medical and Surgical Care (continued)	• In a Skilled Nursing Facility (100-day *benefit limit* per *member* per calendar year)	
	Facility services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	No charge (*deductible* does not apply)
	• Other ambulance	No charge (*deductible* does not apply)
Cardiac Rehabilitation	*Outpatient* services	$35 *copayment* per visit after *deductible*
Chiropractor Services (for *members* of any age)	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services, including spinal manipulation (a *benefit limit* does not apply)	$35 *copayment* per visit (*deductible* does not apply)
Dialysis Services	*Outpatient* services and home dialysis	No charge after *deductible*, except *deductible* does not apply to home dialysis
Durable Medical Equipment	• Covered medical equipment rented or purchased for home use	20% after *deductible*
	• One breast pump per birth (rented or purchased), including related parts and supplies	No charge (*deductible* does not apply)
		No coverage is provided for hospital-grade breast pumps.
Early Intervention Services	*Outpatient* intervention services for eligible child from birth through age two	No charge (*deductible* does not apply)
Emergency Medical Outpatient Services	• Emergency room services	$150 *copayment* per visit (*deductible* does not apply); *copayment* waived if held for observation or admitted within 24 hours
	• Hospital outpatient department services	No charge after *deductible*
	• Office, health center, and home services by your *primary care provider*; or by an OB/GYN physician or nurse midwife; or by a physician assistant or nurse practitioner designated by the health plan as primary care	$20 *copayment* per visit (*deductible* 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:
Emergency Medical Outpatient Services (continued)	• Office, health center, and home services 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	$35 *copayment* per visit (*deductible* does not apply)
Home Health Care	Home care program	No charge (*deductible* does not apply)
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	No charge (*deductible* does not apply)
Infertility Services	• *Inpatient* services	See Admissions for Inpatient Medical and Surgical Care
	• *Outpatient* surgical services	See Surgery as an Outpatient
	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• *Outpatient* lab tests by a general hospital	No charge after *deductible*
	by other *covered providers*	No charge after *deductible*
	• *Outpatient* x-rays and other imaging tests (other than advanced imaging tests) by a general hospital	No charge after *deductible*
	by other *covered providers*	No charge after *deductible*
	• *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging) by a general hospital	No charge after *deductible*
	by other *covered providers*	No charge after *deductible*
	• Other *outpatient* tests and preoperative tests by a general hospital	No charge after *deductible*
	by other *covered providers*	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)	• Maternity services Facility services (*inpatient* and *outpatient covered services*)	No charge after *deductible* for *inpatient* services, otherwise no charge
	Physician and other covered professional provider services (includes delivery and postnatal care)	No charge (*deductible* does not apply)
	• Prenatal care	No charge (*deductible* does not apply)
	• 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)	• Office, health center, and home medical services 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	$20 *copayment* per visit (*deductible* does not apply)
	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	$35 *copayment* per visit, except lower *copayment* applies for infertility treatment (*deductible* does not apply)
	• Hospital outpatient medical services	No charge after *deductible*
	• Acupuncture services (12-visit *benefit limit* per *member* per calendar year)	$35 *copayment* per visit (*deductible* does not apply)
Medical Formulas	Certain medical formulas and low protein foods	No charge (*deductible* 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:
Mental Health and Substance Use Treatment	• *Inpatient* admissions in a General Hospital	
	Hospital services	No charge (*deductible* does not apply)
	Physician and other covered professional provider services	No charge (*deductible* does not apply)
	• *Inpatient* admissions in a Mental Hospital or Substance Use Facility	
	Facility services	No charge (*deductible* does not apply)
	Physician and other covered professional provider services	No charge (*deductible* does not apply)
	• *Outpatient* services	$20 *copayment* per visit, except no charge for hospital services (*deductible* does not apply)
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	No charge after *deductible*
	• *Outpatient* respiratory therapy	No charge after *deductible*
Podiatry Care	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient
	• *Outpatient* medical care services	See Medical Care Outpatient Visits
Prescription Drugs and Supplies Drug Formulary (includes syringes and needles)	• Retail Pharmacy (30-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	 $15 *copayment* $30 *copayment* $50 *copayment*
		This cost share is waived for Tier 1 birth control drugs and devices; certain preventive drugs as required by federal law; insulin infusion pumps; and certain orally-administered anticancer drugs.
	• Mail Order Pharmacy (90-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	 $30 *copayment* $60 *copayment* $150 *copayment*
		This cost share is waived for Tier 1 birth control drugs and devices; certain preventive drugs as required by federal law; and certain orally-administered anticancer drugs.

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	• Routine pediatric care Routine medical exams and immunizations	No charge
	Routine tests	No charge
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.
	Annual mental health wellness exams	No charge
	• Preventive dental care for *members* under age 18 for treatment of cleft lip/cleft palate	No charge
	• Routine adult care Routine medical exams and immunizations	No charge
	Routine tests	No charge
		These *covered services* 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.
	Annual mental health wellness exams	No charge
	• Routine GYN care Routine GYN exams (one exam per *member* per calendar year)	No charge
	Routine Pap smear tests (one test per *member* per calendar year)	No charge
	• Family planning	No charge
	• Routine hearing care Routine hearing exams/tests	No charge
	Newborn hearing screening tests	No charge
	Hearing aids/related services for *members* age 21 or younger ($2,000 for one hearing aid per hearing-impaired ear every 36 months)	No charge

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)	• Routine vision care Routine vision exams (one exam per *member* every 24 months)	No charge
	Vision supplies/related services	Not covered; you pay all charges
Prosthetic Devices	• Ostomy supplies	No charge after *deductible*
	• Artificial limb devices (includes repairs) and other external prosthetic devices	20% after *deductible*
Radiation Therapy and Chemotherapy	• *Outpatient* hospital and free-standing radiation and chemotherapy facility services	No charge after *deductible*
	• Office and health center services by your *primary care provider* or by a physician assistant or nurse practitioner designated by the health plan as primary care	$20 *copayment* per visit (*deductible* does not apply)
	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	$35 *copayment* per visit (*deductible* does not apply)
Second Opinions	*Outpatient* second and third opinions	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy) Includes habilitation services	*Outpatient* services (60-visit *benefit limit* per *member* per calendar year for physical and occupational therapy, except for autism; a *benefit limit* does not apply for speech therapy)	$35 *copayment* per visit 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:
Speech, Hearing, and Language Disorder Treatment	• *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* speech therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* 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)	• *Outpatient* day surgery Hospital surgical day care unit or outpatient department services	No charge after *deductible*
	Ambulatory surgical facility services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*
	• Sterilization procedure for a female *member* when performed as the primary procedure for family planning reasons	No charge (*deductible* does not apply)
	• Office and health center surgical services by your *primary care provider*; or by an OB/GYN physician or nurse midwife; or by a physician assistant or nurse practitioner designated by the health plan as primary care	$20 *copayment* per visit (*deductible* does not apply)
	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	$35 *copayment* per visit, except lower *copayment* applies for infertility treatment (*deductible* does not apply)
TMJ Disorder Treatment	• *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient
	• *Outpatient* physical therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* 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.*