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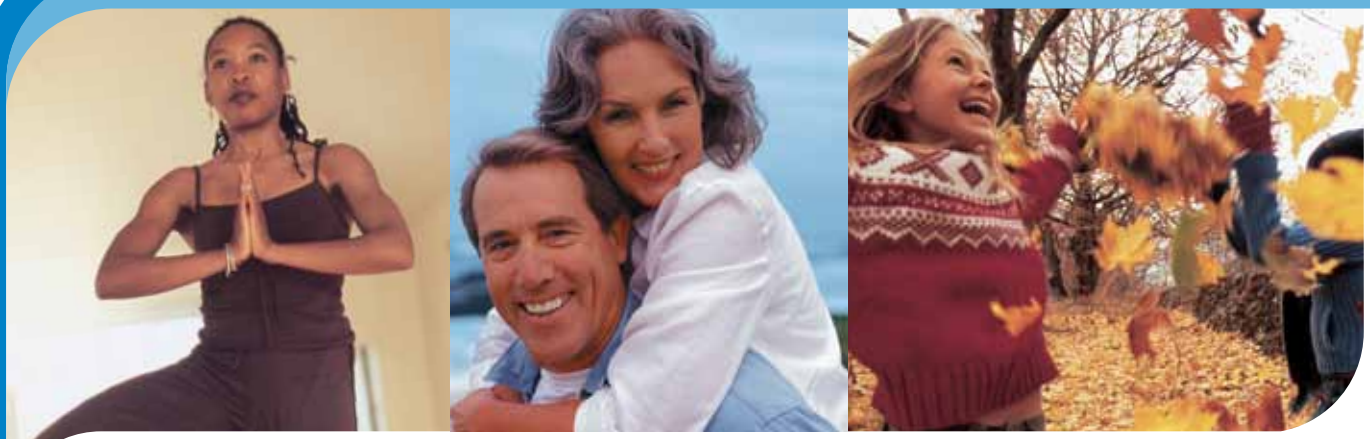

Blue Choice® Plan 2

Summary of Benefits

Town of Lexington

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents effective January 1, 2011, as part of the Massachusetts Health Care Reform Law.

Your Care

Your Primary Care Provider.

When you enroll in Blue Choice, you choose a primary care provider (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 provider 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 descriptions.

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. In Massachusetts, you must choose a health care provider who is a Blue Cross Blue Shield-participating provider for covered non-emergency services. When you choose to seek care on your own from a participating provider, your out-of-pocket cost will be greater. 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.
- 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.

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 **$75** 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.

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 Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

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	$75 per visit (waived if admitted or for observation stay)	$75 per visit, no deductible (waived if admitted or for observation stay)
Well-child care visits	Nothing	20% co-insurance* (through age 5**)
Routine adult physical exams, including related tests	Nothing	20% co-insurance* (limited to blood tests for lead poisoning and covered mammograms)
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	Not covered
Routine hearing exams	Nothing	20% co-insurance* (limited to newborn screening tests)
Routine vision exams (one per calendar year)	Nothing	Not covered
Family planning services–office visits	Nothing	20% co-insurance*
Office visits	$15 per visit	20% co-insurance*
Mental health and substance abuse treatment	$15 per visit	20% co-insurance*
Chiropractor services	$15 per visit (up to 20 visits per calendar year for members age 16 or older)	20% co-insurance*
Short-term rehabilitation therapy–physical and occupational (up to 90 consecutive days per illness or injury per calendar year***)	$15 per visit	20% co-insurance*
Speech, hearing, and language disorder treatment–speech therapy	$15 per visit	20% co-insurance*
Preventive dental care for children under age 12 (one visit each six months)	Nothing	Not covered
Allergy injections only	Nothing	20% co-insurance*
Diagnostic X-rays, lab tests, and other tests	Nothing	20% co-insurance*
Home health care and hospice services	Nothing	20% co-insurance*
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 • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	 $15 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)	$250 per admission††	20% co-insurance*
Mental hospital or substance abuse facility care (as many days as medically necessary)	$250 per admission††	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*

* In addition to your deductible and 20% co-insurance, you may be responsible for any balance of charges above the allowed charge.

** 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 or for the treatment of autism spectrum disorders.

† 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 within 30 days for the same or related illness will not exceed $500. Copayments for inpatient admissions will not exceed $750 in each plan year.

Your Medical Benefits (continued)

Covered Services	Your Cost
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$15 for Tier 1 $25 for Tier 2 $35 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 $50 for Tier 2 $70 for Tier 3

Healthy Blue Programs

At Blue Cross Blue Shield of Massachusetts we offer you 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 information that outlines these special programs.

www.livinghealthybabies.com	No additional charge
Living Healthy Vision℠–discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Safe Beginnings–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 additional charge
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No additional 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.

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