attached to and made part of
Point-of-Service Plan Benefit Description
ASC-POS (1-1-2013)

Schedule of Benefits

Blue Choice® New England Plan 2

This is the *Schedule of Benefits* that is a part of your Benefit Description. 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 Benefit Description 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 the highest level of 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*. **But, when you use an out-of-network provider, you may also have to pay all charges that are in excess of the *allowed charge* for *covered services*. This is called "*balance billing*." These balance billed charges are in addition to the cost share you have to pay for *covered services*. (Exceptions to this paragraph are explained in Part 2.)**

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	PCP/Plan Approved Benefits	Self-Referred Benefits
Deductible Your *deductible* per calendar year is: This *deductible* applies to all self-referred benefits <u>except</u> 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*.	
	\$0 per *member* \$0 per family	\$250 per *member* \$500 per family
	Any costs you pay for PCP/plan approved benefits will <u>not</u> be applied toward the self-referred benefits *deductible*.	
	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 calendar 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 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		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Admissions for Inpatient Medical and Surgical Care	• In a General Hospital		
	<u>Hospital services</u>	No charge	20% after *deductible*
	<u>Physician and other covered professional provider services</u>	No charge	20% after *deductible*
	• In a Chronic Disease Hospital	(same as admissions in a General Hospital)	(same as admissions in a General Hospital)
	• In a Rehabilitation Hospital (60-day *benefit limit* per *member* per calendar year)		
	<u>Hospital services</u>	No charge	20% after *deductible*
	<u>Physician and other covered professional provider services</u>	No charge	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits 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	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	No charge	same as PCP/plan approved benefits
	• Other ambulance	No charge	20% after *deductible*
Cardiac Rehabilitation	*Outpatient* services	$10 *copayment* per visit	20% after *deductible*
Chiropractor Services (for *members* of any age)	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services, including spinal manipulation (a *benefit limit* does not apply)	$10 *copayment* per visit	20% after *deductible*
Dialysis Services	*Outpatient* services and home dialysis	No charge	20% after *deductible*
Durable Medical Equipment	• Covered medical equipment rented or purchased for home use	20%	20% after *deductible*
	• One breast pump per birth (rented or purchased)	No charge	20% after *deductible*
		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	No charge (*deductible* does not apply)
Emergency Medical Outpatient Services	• Emergency room services	$100 *copayment* per visit; *copayment* waived if held for observation or admitted within 24 hours	same as PCP/plan approved benefits
	• Hospital outpatient department services	No charge	20% after *deductible*
	• Office, health center, and home services by your *primary care provider*; or by an OB/GYN physician or nurse midwife; or by any physician assistant or nurse practitioner	$10 *copayment* per visit	20% after *deductible*
	by a network specialist or other *covered provider* (non-hospital)	$10 *copayment* per visit	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Home Health Care	Home care program	No charge	20% after *deductible*
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	No charge	20% after *deductible*
Infertility Services	• *Inpatient* services	See Admissions for Inpatient Medical and Surgical Care	See Admissions for Inpatient Medical and Surgical Care
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• *Outpatient* lab tests	No charge	20% after *deductible*
	• *Outpatient* x-rays	No charge	20% after *deductible*
	• *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)	$25 *copayment** per category of test per service date	20% after *deductible*
	• Other *outpatient* tests and preoperative tests	No charge	20% after *deductible*
Maternity Services and Well Newborn Inpatient Care (includes $90/$45 for childbirth classes; *deductible* does not apply)	• Maternity services Facility services (*inpatient* and *outpatient covered services*)	No charge	20% after *deductible*
	Physician and other covered professional provider services (includes delivery and postnatal care)	No charge	20% after *deductible*
	• Prenatal care	No charge	20% after *deductible*
	• Well newborn care during enrolled mother's maternity admission	No charge	20% (*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 any physician assistant or nurse practitioner	$10 *copayment* per visit	20% after *deductible*
	by a network specialist or other *covered provider* (non-hospital)	$10 *copayment* per visit	20% after *deductible*
	• Hospital outpatient medical services	No charge	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Medical Formulas	Certain medical formulas and low protein foods	No charge	20% after *deductible*
Mental Health and Substance Abuse Treatment	• *Inpatient* admissions in a General Hospital		
	Hospital services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• *Inpatient* admissions in a Mental Hospital or Substance Abuse Facility		
	Facility services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• *Outpatient* services	$10 *copayment* per visit, except no charge for hospital services	20% after *deductible*
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	No charge	20% after *deductible*
	• *Outpatient* respiratory therapy	No charge	20% after *deductible*
Podiatry Care	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	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):	$10 *copayment* $25 *copayment* $45 *copayment*	Not covered; you pay all charges
		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 Service Pharmacy (90-day supply)		
	Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	$20 *copayment* $50 *copayment* $90 *copayment*	Not covered; you pay all charges
		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		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Preventive Health Services	• Routine pediatric care Routine medical exams and immunizations	No charge	20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		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.	
	• Preventive dental care for *members* under age 18 for treatment of cleft lip/cleft palate	No charge	20% after *deductible*
	• Routine adult care Routine medical exams and immunizations	No charge	20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; routine mammograms (may be subject to age and frequency requirements); blood tests to screen for lead poisoning; and routine colonoscopies.	
	• Routine GYN care Routine GYN exams (one exam per *member* per calendar year)	No charge	20% after *deductible*
	Routine Pap smear tests (one test per *member* per calendar year)	No charge	20% after *deductible*
	• Family planning	No charge	20% after *deductible*
	• Routine hearing care Routine hearing exams/tests	No charge	20% after *deductible*
	Newborn hearing screening tests	No charge	20% after *deductible*
	Hearing aids/related services	Not covered; you pay all charges	Not covered; you pay all charges
	• Routine vision care Routine vision exams (one exam per *member* every 24 months)	No charge	20% after *deductible*
	Vision supplies	Not covered; you pay all charges	Not covered; you pay all charges
Prosthetic Devices	• Ostomy supplies	No charge	20% after *deductible*
	• Artificial limb devices (includes repairs) and other external prosthetic devices	20%	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Radiation Therapy and Chemotherapy	*Outpatient* services	No charge	20% after *deductible*
Second Opinions	*Outpatient* second and third opinions	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy)	*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)	$10 *copayment* per visit	20% after *deductible*
Speech, Hearing, and Language Disorder Treatment	• *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* speech therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Surgery as an Outpatient (includes removal of impacted teeth that are fully or partially imbedded in the bone)	• *Outpatient* day surgery Hospital surgical day care unit or outpatient department services	No charge	20% after *deductible*
	Ambulatory surgical facility services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• Sterilization procedure for a female *member* when performed as the primary procedure for family planning reasons	No charge	20% after *deductible*
	• Office and health center surgical services by your *primary care provider*; or by an OB/GYN physician or nurse midwife; or by any physician assistant or nurse practitioner	$10 *copayment* per visit	20% after *deductible*
	by a network specialist or other *covered provider* (non-hospital)	$10 *copayment* per visit	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
TMJ Disorder Treatment	• *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* physical therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

*The total amount you pay for *copayments* for these advanced imaging tests will not exceed $375 per *member* per calendar year.

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

Rider 02-360

Office Surgery

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description for office or health center surgery have been changed.

Any *deductible, copayment*, and/or *coinsurance* that you would normally pay for covered surgical services furnished in a *network provider's* office or in a network health center no longer applies. For these *covered services*, you pay nothing.

All other provisions remain as described in your Benefit Description.

Rider 03-304

Infertility Services

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *inpatient* and *outpatient* benefits described in your Benefit Description for infertility services have been changed.

No self-referred benefits are provided for services to diagnose or treat infertility. When you chose to self-refer for these services, you must pay all charges.

All other provisions remain as described in your Benefit Description.

Rider 04-312

Diagnostic Tests

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The amount that you pay for certain covered diagnostic tests as described in your Benefit Description has been changed.

The *copayment* that you would normally pay for *outpatient* computerized axial tomography (CT scans), magnetic resonance imaging (MRI), positron emission tomography (PET scans), and nuclear cardiac imaging tests has been eliminated. For these *covered services*, you pay nothing.

All other provisions remain as described in your Benefit Description.

Rider 05-545

Mental Health and Substance Abuse Treatment

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description for mental health and substance abuse treatment have been changed.

The *copayment* amount that you would normally pay for *outpatient* mental health and substance abuse visits no longer applies. For these *covered services*, you pay nothing.

All other provisions remain as described in your Benefit Description.

Rider 06-001

Short-Term Rehabilitation Therapy

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *outpatient* self-referred benefits described in your Benefit Description for short-term rehabilitation therapy have been changed.

This health plan provides self-referred benefits for short-term rehabilitation therapy for as many visits as are *medically necessary* for your illness or injury.

Note: Your PCP/plan approved benefits for short-term rehabilitation therapy have not been changed by this rider.

All other provisions remain as described in your Benefit Description.

Rider 10-2131
Copayments

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The *copayment* amount for certain *outpatient covered services* has been changed from the amount described in your Benefit Description to:

(1) $15 *copayment* for each visit for the following *covered services*:
- cardiac rehabilitation services;
- medical care services to diagnose or treat your illness, condition, or injury, when the *covered service* is furnished by your *primary care provider* or by a network obstetrician, network gynecologist, network nurse practitioner, network nurse midwife, or network physician assistant;
- medical care services for treatment of infertility;
- mental health and/or substance abuse treatment; and
- speech/language therapy.

(2) $20 *copayment* for each visit for the following *covered services*:
- medical care services to diagnose or treat your illness, condition, or injury, when the *covered service* is furnished by a network specialist, including (but not limited to) a network chiropractor or a network podiatrist; and
- physical and occupational therapy.

Refer to your *Schedule of Benefits* for a description of the *covered services* for which the lower and higher *copayments* apply.

Note: This *rider* does not change the amount you must pay for: emergency room visits; diagnostic tests (such as lab tests and imaging tests); prescription drugs; and *outpatient* day surgery.

All other provisions remain as described in your Benefit Description.

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Your Health Plan Benefit Description

Rider
Deductible

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The *deductible* amount as shown in your *Schedule of Benefits* has been changed as follows:

Your *deductible* per calendar year is: $300 per *member*
$600 per family

Refer to your *Schedule of Benefits* (and, if applicable, other *riders* that are part of your health plan) for a description of *covered services* for which the *deductible* applies.

All other provisions remain as described in your Benefit Description.

attached to and made part of
Your Health Plan Benefit Description

Rider
Out-of-Pocket Maximum

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The *out-of-pocket maximum* as shown in your *Schedule of Benefits* has been changed as follows:

Overall Member Cost Share Provisions	PCP/Plan Approved Benefits	Self-Referred Benefits
Out-of-Pocket Maximum	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*.	
Your *out-of-pocket maximum* per calendar year is: This *out-of-pocket maximum* is a total of the *deductible*, *copayments*, and *coinsurance* you pay for *covered services*.	$2,000 per *member* $4,000 per family (excluding cost share amounts for prescription drugs)	
	and a separate *out-of-pocket maximum* for 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*.	

All other provisions remain as described in your Benefit Description.

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Rider
Prescription Drugs

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

Your cost share amount for covered drugs and supplies you buy from a covered pharmacy is:

- **Retail Pharmacy** (30-day supply):
  Tier 1 (generic): $10 *copayment*
  Tier 2 (preferred brand): $15 *copayment*, except $10 *copayment* for generic
  Tier 3 (non-preferred): $35 *copayment*

- **Mail Service Pharmacy** (90-day supply):
  Tier 1 (generic): $10 *copayment*
  Tier 2 (preferred brand): $15 *copayment*, except $10 *copayment* for generic
  Tier 3 (non-preferred): $35 *copayment*

Note: The cost share for birth control drugs, diaphragms, and other birth control devices that are classified as Tier 1 drugs or supplies will be waived (except when your health plan is a grandfathered health plan under the Affordable Care Act). Refer to your Benefit Description for other times when your cost share for covered drugs and supplies will be waived.

All other provisions remain as described in your Benefit Description.

Rider 14-006

Routine Vision Exams

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The benefits described in your Benefit Description for routine vision exams have been changed.

No benefits are provided for routine vision exams. For these services, you must pay all charges.

Note: Your benefits for medical care services and contact lenses needed to treat keratoconus and intraocular lenses implanted (or one pair of eyeglasses instead) after covered eye surgery when the natural eye lens is replaced have not been changed.

All other provisions remain as described in your Benefit Description.

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Rider
Hearing Aids and Related Services

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description have been changed by adding coverage for hearing aids and related services.

This health plan covers hearing aids and related services for a *member* of any age, when the hearing aid and related services are furnished by a *covered provider,* such as a licensed audiologist or licensed hearing instrument specialist. This coverage includes:

- For a *member* who is age 21 or younger: One hearing aid for each hearing-impaired ear every 36 months and the following related services: initial hearing aid evaluation; fitting and adjustments of the hearing aid; hearing aid batteries; repair of broken hearing aids, and supplies such as (but not limited to) ear molds. **Your benefits for the hearing aid device itself are limited to $2,000 for each covered hearing aid.** If you choose a hearing aid device that costs more than this *benefit limit*, you will have to pay the balance of the cost of the device that is in excess of the *benefit limit*. This *benefit limit* does not apply to services related to a covered hearing aid.
- For a *member* who is age 22 or older: One hearing aid or one set of binaural hearing aids per *member* every 36 months and the following related services: initial hearing aid evaluation; fitting and adjustments of the hearing aid; hearing aid batteries; repair of broken hearing aids, and supplies such as (but not limited to) ear molds. **Your benefits for the hearing aid device and related *covered services* are limited to a total of $2,000 per *member* every 36 months.** You will have to pay the balance of the cost that is in excess of the *benefit limit*.

For these *covered services*, you cost share amount (*deductible*, *copayment*, and *coinsurance*, whichever normally applies) is waived.

No benefits are provided for hearing aids delivered more than 60 days after your termination date in this health plan, even if the hearing aid was prescribed while you were covered by the health plan.

All other provisions remain as described in your Benefit Description.

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Rider
Durable Medical Equipment

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The cost share amount you pay for durable medical equipment as shown in your *Schedule of Benefits* has been changed as follows:

You will pay 30% *coinsurance* for PCP/plan approved benefits or for self-referred benefits, after you have paid your overall *deductible*, you will pay 50% *coinsurance.*

This change does not apply to your coverage for the women's preventive health services (such as one breast pump per birth) that are recommended by the U.S. Department of Health and Human Services for which you have the right to full coverage as described in your Benefit Description.

All other provisions remain as described in your Benefit Description.

Rider 15-423
Prosthetic Devices

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The amount you pay for *outpatient* covered prosthetic devices has been changed from the amount described in your Benefit Description to: no cost for PCP/Plan Approved benefits or 20% *coinsurance* after *deductible* for Self-Referred benefits.

All other provisions remain as described in your Benefit Description.

Rider 18-308
Chiropractor Services

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description for *covered services* furnished by a chiropractor have been changed.

Your benefits for *outpatient* chiropractic services furnished by a chiropractor are limited to 20 visits each calendar year for each *member* (regardless of age). Once you reach this *benefit limit*, no more benefits will be provided for chiropractor services during the rest of that year, whether or not these chiropractic services are *medically necessary* for you.

All other provisions remain as described in your Benefit Description.

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Rider
Open Drug Formulary

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description for covered drugs and supplies have been changed.

Under your health plan, the *Blue Cross and Blue Shield* Drug Formulary is an "open" formulary list. This means that the Drug Formulary Exception Process as described in your Benefit Description no longer applies. To find out which *member* cost share level you will pay for a specific covered drug or supply, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.

All other provisions remain as described in your Benefit Description.