

**NORTHERN NEW ENGLAND BENEFIT TRUST
 BLUE CROSS BLUE SHIELD OF MASSACHUSETTS
 HMO Blue-Plus Plan Summary**

Benefits outlined below are intended only as a general summary.

All services and treatments must be performed by a network provider, and all admissions must be to a network facility. There is no coverage for Out-of-Network providers.

GENERAL PLAN INFORMATION

COVERED SERVICES	MEMBER COST
ANNUAL DEDUCTIBLE	No deductible
MAXIMUM OUT-OF-POCKET EXPENSE <i>(per calendar year; co-payments do not apply)</i>	No Maximum Out-of-Pocket
LIFETIME MAXIMUM	<i>Eliminated 1/1/11</i>

OFFICE VISITS AND PREVENTIVE CARE

COVERED SERVICES	MEMBER COST
Routine Physical Examination	\$15 per visit
Well Baby/Child Check-up/Immunizations	\$15 per visit
Routine Gynecological Exam (one per year)	\$25 per visit
Regular Office Visit - <i>Primary Care Doctor (PCP), Family Practice, Pediatrician, Internist)</i>	\$15 per visit
Specialist Office Visit <i>[not limited to but including] Dermatologist, Podiatrist, Cardiologist, etc.</i>	\$25 per visit
Allergy Testing/Treatment <i>(no office co-pay for injection only)</i>	\$25 per visit
Allergy injections	No charge
Injections / Immunizations administered at PCP office	\$15 per visit
Surgery performed in a doctor's office	\$15 (PCP) or \$25 (Specialist) per visit
Obstetrics Services/Pre-Natal Examination <i>(Co-pay for first visit only)</i>	\$25 <i>(first visit only)</i>

CHIROPRACTIC BENEFITS

COVERED SERVICES	MEMBER COST
Medical care services, including spinal manipulation	\$25 per visit
Labs and x-rays <i>(does not include MRI or CAT scans)</i>	No charge

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LABORATORY AND RADIOLOGY

COVERED SERVICES	MEMBER COST
X-rays and laboratory tests	No charge
Routine Mammography	No charge
High Tech Radiology (PET, CT, MRI)	\$100 per scan

HOSPITAL CARE

COVERED SERVICES	MEMBER COST
Same day or outpatient surgery and procedures <i>(not admitted as a patient)</i>	No charge
Inpatient services <i>(admitted as a patient)</i> Including but not limited to: Childbirth and Newborn Care Physician Visits and Services/Nursing Care Anesthesiologist Services/Operating room Intensive Care Unit Laboratory and Radiology Medications and Supplies	No charge

EMERGENCY CARE

COVERED SERVICES	MEMBER COST
Emergency room visits	\$100 per visit (waived if admitted)
Ambulance - Air and ground <i>(medically necessary)</i>	No charge

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CONTINUED CARE	
COVERED SERVICES	MEMBER COST
Short-term rehabilitative therapy — physical, occupational. <i>(Limit of 60 visits per member per calendar year.)</i>	\$25 per visit up to the benefit limit; then member pays all costs.
Short-term speech/hearing and language disorder diagnosis and treatment. <i>(Limit of 60 visits per member per calendar year.)</i>	\$25 per visit up to the benefit limit; then member pays all costs.
Cardiac rehabilitative therapy	\$25 per visit
Home health care <i>(medically necessary)</i>	No charge
Hospice care, inpatient or outpatient services for terminally ill	No charge
Care in a designated skilled nursing facility <i>(up to 100 days per calendar year)</i>	No charge up to the benefit limit; then member pays all costs.
Care in a network rehabilitation hospital <i>(up to 60 days per calendar year)</i>	No charge up to the benefit limit; then member pays all costs.

WEIGHT LOSS BENEFITS	
<i>For complete details and restrictions please visit www.bluecrossma.com or call the customer service telephone number on your health plan ID card.</i>	
COVERED SERVICES	REIMBURSEMENT
Weight Loss Benefit: Only applies to Hospital-based or Blue Cross Blue Shield designated non-hospital based programs.	\$150 per calendar year; all enrolled members combined (\$150 per family)

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MENTAL HEALTH/SUBSTANCE ABUSE

All services must be approved in advance by Blue Cross Blue Shield (1-800-524-4010) and a network provider must be used.

COVERED SERVICES	MEMBER COST
Inpatient admissions in a network General Hospital	No charge
Inpatient admissions in a network Mental Hospital or Substance Abuse Facility	No charge
Outpatient Services	\$15 per visit

DURABLE MEDICAL EQUIPMENT

All equipment must be purchased or rented from a designated Blue Cross Blue Shield provider and be considered medically necessary.

COVERED SERVICES	MEMBER COST*
Durable medical equipment (including but not limited to glucometers, wheelchairs, crutches, hospital beds, back/knee braces).	Covered to a maximum of \$1,500 per member per calendar year; then member pays all costs.

NOTE: \$1,500 annual limit will apply to items considered non-essential durable medical equipment by the Patient Protection and Affordable Care Act (at the time of printing, regulations have not been finalized).