NORTHERN NEW ENGLAND BENEFIT TRUST

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS

HMO Blue 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 *(per calendar year; co-payments do not apply)*	$2,000 per individual; $4,000 per family
LIFETIME MAXIMUM	*Eliminated 1/1/11*

OFFICE VISITS AND PREVENTIVE CARE	
COVERED SERVICES	MEMBER COST
Routine Physical Examination	$20 per visit
Well Baby/Child Check-up/Immunizations	$20 per visit
Routine Gynecological Exam (one per year)	$25 per visit
Regular Office Visit - *Primary Care Doctor (PCP), Family Practice, Pediatrician, Internist)*	$20 per visit
Specialist Office Visit *[not limited to but including] Dermatologist, Podiatrist, Cardiologist, etc.*	$25 per visit
Allergy Testing/Treatment *(no office co-pay for injection only)*	$25 per visit
Allergy injections	No charge
Injections / Immunizations administered at PCP office	$20 per visit
Surgery performed in a doctor's office	$20 (PCP) or $25 (Specialist) per visit
Obstetrics Services/Pre-Natal Examination *(Co-pay for first visit only)*	$25 *(first visit only)*

CHIROPRACTIC BENEFITS	
COVERED SERVICES	MEMBER COST
Medical care services, including spinal manipulation Labs and x-rays *(does not include MRI or CAT scans)*	$25 per visit 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 *(not admitted as a patient)*	* $150 per admission
Inpatient services *(admitted as a patient) 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	* $500 per admission to a maximum out-of-pocket of $2,000 per individual/$4,000 per family

EMERGENCY CARE

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

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CONTINUED CARE

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

WEIGHT LOSS BENEFITS

For complete details and restrictions please visit www.bluecrossma.com or call the customer service telephone number on your health plan ID card.

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	$500 per admission
Inpatient admissions in a network Mental Hospital or Substance Abuse Facility	$500 per admission
Outpatient Services	$20 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 $750 per member per calendar year; then member pays all costs.

NOTE: $750 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).