

**NORTHERN NEW ENGLAND BENEFIT TRUST  
 BLUE CROSS BLUE SHIELD OF MASSACHUSETTS  
 Local 122 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
<b>ANNUAL DEDUCTIBLE</b>	No deductible
<b>MAXIMUM OUT-OF-POCKET EXPENSE</b> <i>(per calendar year; co-payments do not apply)</i>	\$1,000 per individual; \$2,000 per family
<b>LIFETIME MAXIMUM</b>	<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)	\$15 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>	\$15 per visit
Allergy Testing/Treatment <i>(no office co-pay for injection only)</i>	\$15 per visit
Allergy injections	No charge
Injections / Immunizations administered at PCP office	\$15 per visit
Surgery performed in a doctor's office	\$15 per visit
Obstetrics Services/Pre-Natal Examination <i>(Co-pay for first visit only)</i>	\$15 (first visit only)

**CHIROPRACTIC BENEFITS**

COVERED SERVICES	MEMBER COST
Medical care services, including spinal manipulation	\$15 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)	No charge

**HOSPITAL CARE**

COVERED SERVICES	MEMBER COST
Same day or outpatient surgery and procedures <i>(not admitted as a patient)</i>	* \$150 per admission
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	* \$500 per admission to a maximum out-of-pocket of \$1,000 per individual/\$2,000 per family

**EMERGENCY CARE**

COVERED SERVICES	MEMBER COST
Emergency room visits	\$50 per visit (waived if admitted)
Ambulance - Air and ground <i>(medically necessary)</i>	No charge

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<b>CONTINUED CARE</b>	
<b>COVERED SERVICES</b>	<b>MEMBER COST</b>
Short-term rehabilitative therapy — physical, occupational. <i>(Limit of 60 visits per member per calendar year.)</i>	\$15 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>	\$15 per visit up to the benefit limit; then member pays all costs.
Cardiac rehabilitative therapy	\$15 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.

<b>WEIGHT LOSS BENEFITS</b>	
<i>For complete details and restrictions please visit <a href="http://www.bluecrossma.com">www.bluecrossma.com</a> or call the customer service telephone number on your health plan ID card.</i>	
<b>COVERED SERVICES</b>	<b>REIMBURSEMENT</b>
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	\$250 per admission
Inpatient admissions in a network Mental Hospital or Substance Abuse Facility	\$250 per admission
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 \$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).*