

# Medical Plan Benefit Chart

Covered services include but are not limited to those listed here. All benefits are subject to specific limitations, coinsurance, deductibles, exclusions and specified payment maximums as described elsewhere in this SPD and subject to the medical policy provisions of Blue Cross Blue Shield of Massachusetts.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
<p><b>Calendar-Year Deductible</b> (does not apply to services that are subject to a co-pay)</p>	\$400 per individual/\$800 per family (applies to in-network and out-of-network covered services combined)	
<p><b>Calendar-Year Out-of-Pocket Maximum</b> (includes coinsurance only)</p>	<p>Once you pay \$5,000 in coinsurance costs per individual or family (excluding deductible and co-pays), you receive 100% coverage for most services subject to coinsurance for the balance of the year.</p> <p>Services you receive from out-of-network providers are covered at 80% after you meet the out-of-pocket maximum, unless the services are related to a medical emergency admission; in this case, they are covered at 100%.</p> <p>Services subject to specific limits, such as durable medical equipment, or services subject to a co-pay, do not count toward the out-of-pocket maximum.</p>	
<b>Acute Hospital Facility Care</b>		
<p><b>Inpatient Admissions for Medical and Surgical Care</b> (including Maternity)</p> <p><b>Room and board</b> (up to the average semi-private room rate), intensive care confinement and all ancillary and special services billed by the hospital</p> <p><b>Admissions</b> (other than maternity) must be pre-authorized by Blue Cross Blue Shield</p>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible; 15% coinsurance after deductible if Blue Cross Blue Shield determines the admission is a medical emergency

### Maternity Admissions

You do not need to pre-authorize your normal maternity hospital admission. You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. An extended maternity admission is covered if medically necessary and pre-authorized. Covered services include well newborn care, routine circumcision and semi-private room and board and special services for the mother and newborn. Nursery charges for a well newborn are included with the benefits for the mother's maternity admission.

All expectant mothers enrolled in the Plan may take part in a program that provides support and education for expectant mothers. Through this Blue Cross Blue Shield program you receive outreach and education that add to the care you get from your obstetrician or nurse midwife.

### All Admissions

Inpatient ancillary charges billed by a hospital include: use of operating rooms and other surgical treatment rooms; recovery and delivery rooms; anesthesia and its administration (when administered by an employee of the hospital); diagnostic lab and X-ray services; chemotherapy and radiation therapy; radium, radioactive isotopes, and X-ray therapy; renal dialysis; medical supplies such as casts, splints and trusses; blood or blood plasma and its administration; oxygen and equipment for its administration; use of durable medical equipment while you are in the hospital such as inhalators, suction machines, respirators, oxygen tents, and hyperbaric oxygen chambers; drugs and medicines you receive while you are an inpatient; and physiotherapy. Private rooms are covered only if you must be isolated to prevent contagion.

If you do not pre-authorize your inpatient admission before you receive care, the Plan will apply a penalty by reducing its payment by \$250. You should make every effort to notify Blue Cross Blue Shield as soon as possible after an emergency admission; if an authorization is not initiated within two days of an emergency admission, the Plan will apply a penalty by reducing its payment by \$250. Reductions due to payment penalties do not count toward meeting your out-of-pocket maximum.

**The Plan will not cover services determined to be medically unnecessary. If it is determined that your admission was not medically necessary, your claim could be denied altogether. If this occurs, you will be responsible for the full cost of your care.**

	<b>YOUR COST IN-NETWORK</b>	<b>YOUR COST OUT-OF-NETWORK</b>
<p><b>Outpatient Facility Care</b></p> <p>Includes outpatient facility charges and medical services billed by the outpatient department of a facility including: chemotherapy and radiation therapy; renal dialysis; and IV therapy; respiratory therapy; cardiac rehabilitation; ambulatory surgery; emergency medical services; medical and surgical supplies; therapeutic radiology; CT, MRI and other scans; and physical therapy. (Does not include outpatient diagnostic lab and X-ray. See below for details.)</p>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
<p><b>Emergency Room</b></p> <p>Facility and Physician charges</p>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible; or 15% coinsurance after you pay your deductible, if a medical emergency
<p><b>Ambulatory or Inpatient Surgery</b></p> <p>Surgical day care unit of a hospital or free-standing ambulatory surgical facility or as an inpatient. Inpatient procedures must be pre-authorized by Blue Cross Blue Shield and other care must meet Blue Cross Blue Shield medical policy guidelines.</p>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible

**YOUR COST IN-NETWORK****YOUR COST OUT-OF-NETWORK**

Covered surgical procedures include: routine circumcision of an infant; voluntary sterilization procedures; termination of pregnancy to prevent the death of the mother; endoscopic procedures; cataract surgery; and surgical procedures (including emergency and scheduled surgery). These surgical services include (but are not limited to): the incision, excision, or electro-cauterization of any part of the body; the manipulative redirection of a fracture or dislocation; the suturing of a wound; or the removal by endoscopic means of a stone or other foreign object from the body. If two or more procedures are performed during the course of a single operation through the same incision, or in the same operative field, eligible charges for the additional procedures will be reduced by 50%. An assistant surgeon's eligible charges shall not exceed 20% of the primary surgeon's eligible charge.

Reconstructive surgery is non-dental surgery that is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury. This includes reconstructive surgery for a mastectomy and election of breast reconstruction in connection with the mastectomy. As required by federal law, these benefits are provided for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications at all stages of mastectomy, including lymph edemas. These services will be furnished in a manner determined in consultation with the attending physician and patient.

**Ambulance**

Ambulance service for medically necessary transport to the nearest facility equipped to provide the service required	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible or 15% coinsurance after you pay your deductible if medical emergency
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**Non-Acute Facility Care**

Extended Care Facility  Inpatient care in a Skilled Nursing Facility or Rehabilitation hospital for skilled services limited to 100 days per admission; must be pre-authorized by Blue Cross Blue Shield.	15% coinsurance after you pay your deductible and amounts above per-admission limits	30% coinsurance after you pay your deductible and amounts above per-admission limits
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If you require skilled nursing care or rehabilitation care, but not the extensive technological support of an acute care hospital, the Plan covers your inpatient care in an extended care facility. An extended care facility is an institution (or part of an institution) licensed to provide convalescent or skilled nursing care to resident patients and is or could be certified as an extended care facility under Medicare.

Extended care facility benefits will be restored for each new period of confinement. A new period of confinement begins at least 60 days after your last confinement. To be eligible for extended care facility benefits, you must be admitted to the extended care facility for non-routine care at the recommendation and under the supervision of your doctor and services must be pre-authorized by Blue Cross Blue Shield.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
<b>Home Health Care</b>		
<b>Home Health Care</b>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
Skilled care; must be pre-authorized by Blue Cross Blue Shield		
<p><b>To be covered under the Plan, home health care must be:</b></p> <p>Under the order and direct supervision of your doctor;</p> <ul style="list-style-type: none"> <li>• In lieu of continued hospital or extended care facility services;</li> <li>• Furnished by a licensed home health care agency, a hospital or a licensed visiting nurse association; and</li> <li>• Pre-authorized by Blue Cross Blue Shield.</li> </ul> <p>When you meet these requirements, the Plan covers the following home health care services:</p> <ul style="list-style-type: none"> <li>• Part-time (less than an eight-hour shift) skilled nursing visits by a registered nurse (RN) or licensed practical nurse (LPN), but not by someone who is a family member or resident of your household;</li> <li>• Medical social work;</li> <li>• Physical therapy, speech/language therapy (to restore speech to someone who has lost existing speech function as the result of a disease or injury), and occupational therapy;</li> <li>• Nutritional consultation services;</li> <li>• Part-time or intermittent home health aide services provided by a home health aide and under the supervision of an RN (up to four hours per visit);</li> <li>• Medical supplies and equipment suitable for home use; and</li> <li>• Enteral infusion therapy and basic hydration therapy furnished by a coordinated home health agency, including the infusion solution, preparation of the solution and equipment for its administration and necessary part time nursing furnished by a home infusion therapy provider.</li> </ul> <p>These benefits are provided only when the patient is expected to reach a defined medical goal set by the patient's attending physician and, for medical reasons, the patient is not reasonably able to travel to another treatment site where medically appropriate care can be furnished for the patient's condition. No benefits are provided for meals, personal comfort items and housekeeping services; custodial care; and treatment of mental conditions.</p>		

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
<b>Hospice Care</b>		
<b>Inpatient or Outpatient Hospice</b> care services must be pre-authorized by Blue Cross Blue Shield	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
<p>Hospice care is an alternative to hospital confinement, designed to meet the physical and emotional needs of the terminally ill patient and his or her family. Hospice care aims to help both the patient and family cope with terminal illness and to control its pain and symptoms. Hospice care benefits are available to patients who are diagnosed as terminally ill and have six or fewer months to live and services must be pre-authorized by Blue Cross Blue Shield. Hospice care may be delivered in the patient's home, in a specialized hospice care center, or by a hospital.</p> <p>Inpatient hospice care benefits are payable when there are no suitable caregivers available to provide home hospice care and it is determined by the hospice agency that home hospice care is impractical because the patient is unmanageable by the persons who regularly assist with home care. Inpatient hospice care is also payable for respite care, which allows short-term inpatient stays necessary for the patient to give temporary relief to a caregiver who regularly assists with home care. Inpatient respite care is limited to individual stays of no more than five consecutive days.</p>		
<b>Professional Care (services billed by physician's office)</b>		
<b>Physician Office Visit</b>  Covered services include: evaluation and management codes billed by a physician; in-office consultations; second surgical opinion; immunizations; allergy serum and injections; in-office surgery; and machine tests, when performed in the office.  You may incur additional charges for diagnostic lab and X-ray services if they are billed on a different date or by another provider, or if your physician refers you to a hospital or an out-of-network provider.	\$25 co-pay	30% coinsurance after you pay your deductible
<b>Preventive Care</b>		
<b>Routine Adult Physical</b>  Covered annually.  You may incur additional charges for diagnostic lab or X-ray services if they are billed on a different date or by another provider.	\$25 co-pay	30% coinsurance after you pay your deductible

Participants may substitute their Department of Transportation (DOT) physical in lieu of their covered physical every two years.

The following preventive services are covered annually for adults:

- History and risk assessment;
- Chest X-ray;
- EKG;
- Urinalysis;
- Basic and comprehensive metabolic panel;
- Complete blood count;
- Fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides);
- Chlamydial infection test;
- Fecal occult blood test;
- Prostate specific antigen test; and
- Routine immunizations including hepatitis (type A and B) for patients with increased risk or family history, influenza and pneumococcal vaccines, Lyme disease, tetanus-diphtheria (Td) booster (once every ten years).

Cancer screening via sigmoidoscopy (every five years) or colonoscopy (every ten years) are covered after age 50. The Plan covers these services as a hospital and/or surgical benefit subject to deductible and coinsurance.

	<b>YOUR COST IN-NETWORK</b>	<b>YOUR COST OUT-OF-NETWORK</b>
<p><b>Routine Child Physical</b></p> <p>Covered based on this schedule:</p> <ul style="list-style-type: none"> <li>• Birth to 12 months: six visits per year</li> <li>• 12 to 24 months: three visits per year</li> <li>• 24 months to age 19: one visit per year</li> </ul> <p>You may incur additional charges for diagnostic lab or X-ray services if they are billed on a different date or by another provider.</p>	\$25 co-pay	30% coinsurance after you pay your deductible
<p>The following preventive care services are covered as part of a routine child physical:</p> <ul style="list-style-type: none"> <li>• Medical history;</li> <li>• Physical examination;</li> <li>• Measurements;</li> <li>• Sensory screening;</li> <li>• Assessments;</li> <li>• Hereditary and metabolic screening (at birth only);</li> <li>• Appropriate immunizations;</li> <li>• Tuberculin tests; and</li> <li>• Hematocrit, hemoglobin or other appropriate blood tests.</li> </ul>		
<p><b>Routine Gynecological Exam</b></p> <p>Covered annually beginning at age 16</p>	\$25 co-pay	30% coinsurance after you pay your deductible.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
<b>Medical and Surgical Care</b>		
<b>Physician Inpatient or Outpatient Medical Care</b>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
When you receive physician services at a hospital or in an emergency room		
<b>Physician Maternity Care</b>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
Includes global maternity fee for most pre-natal and inpatient care		
<p>Laboratory tests that are part of your pre-natal care are covered after a \$10 co-pay when received from a Blue Cross Blue Shield independent lab or physician office. Pre-natal lab work processed through a preferred hospital is covered after the 15% coinsurance without application of the deductible. Birthing centers are covered at the same level as inpatient hospital benefits. Childbirth education classes are reimbursed based on a fee schedule (contact the Fund Office for details). Family planning services for contraception are covered under the office visit benefit. Voluntary sterilization is covered after a co-pay when performed in-office or after the deductible and coinsurance, if performed in a facility. The Plan does not cover routine screening ultrasounds; ultrasounds must be medically necessary to be covered.</p>		

	<b>YOUR COST IN-NETWORK</b>	<b>YOUR COST OUT-OF-NETWORK</b>
<p><b>Physician Surgery Care</b></p> <p>Inpatient or outpatient, including charges for surgery, anesthesia, surgical pathology, supplies, casts and diagnostic testing performed as part of a surgical procedure performed at a hospital or ambulatory surgical facility</p>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
<p>The Plan covers charges for services of a licensed surgeon, assistant surgeon and anesthesiologist for a surgical procedure involving the:</p> <ul style="list-style-type: none"> <li>• Incision, excision, or electro-cauterization of any part of the body;</li> <li>• Manipulative redirection of a fracture or dislocation;</li> <li>• Suturing of a wound; or</li> <li>• Removal by endoscopic means of a stone or other foreign object from the body.</li> </ul> <p>If two or more procedures are performed during the course of a single operation through the same incision, or in the same operative field, eligible charges for the additional procedures will be reduced by 50%. An assistant surgeon's eligible charge shall not exceed 20% of the primary surgeon's eligible charge.</p> <p>Covered surgery benefits also include: biopsy of tumors and cysts; voluntary sterilization; circumcision of newborn; correction of congenital anomalies; treatment of burns; insertion of prosthetic devices; assistant surgeon if complexity requires one; dental surgery related to an accidental injury (other than chewing); gastric bypass, if you meet clinical requirements; initial placement of contact lenses or initial lens implant required because of cataract surgery; and surgery related to temporomandibular joint (TMJ) disorders. All TMJ medical care and surgery is limited to a \$2,500 lifetime maximum per person.</p> <p>If you receive care in a PPO network hospital from a non-contracting radiologist, anesthesiologist, pathologist or emergency room physician, your services are covered at the in-network rate, since you have no control over who treats you in these situations. Contact the Plan if your claim has not been processed at the in-network level of benefits in this situation.</p>		

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
<b>Lab and X-ray</b>		
<b>In-Office Diagnostic Lab or X-ray</b>  Charges billed by your physician (on a date different from your office visit)	\$10 co-pay	30% coinsurance after you pay your deductible
<b>Lab or X-ray</b>  Billed by an independent lab	\$10 co-pay	30% coinsurance after you pay your deductible
<b>Diagnostic Lab or X-ray</b>  Billed by any provider or facility as part of a covered physical	\$10 co-pay	30% coinsurance after you pay your deductible
<b>Diagnostic Lab or X-ray</b>  Billed by the outpatient department of a hospital	15% coinsurance only, no deductible applies (See the definition of diagnostic lab and X-ray services below.)	30% coinsurance after you pay your deductible
<b>Lab or X-ray</b>  Billed by an emergency room, emergency room physician, ambulatory surgery facility, surgeon or anesthesiologist, or billed when you are an inpatient, or for treatment not related to diagnostic lab or X-ray received in the outpatient department of a hospital.	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
	Covered diagnostic lab and X-ray services include the following types of services when billed by the outpatient department of a hospital: laboratory services; X-rays; ultrasound imaging; bone density tests; machine tests; and follow-up mammography. Covered services do not include CT, MRI or PET scans.	
<b>Routine Mammogram</b>  Imaging and radiologist review charges, when performed at any site.  Covered annually after age 35	\$10 co-pay for imaging  \$10 co-pay for radiologist review	30% coinsurance after you pay your deductible
<b>Routine Pap Test</b>  Laboratory charges when performed at any site	\$10 co-pay	30% coinsurance after you pay your deductible
<b>MRI, CT and PET Scans</b>  Imaging charges billed by any site	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible

	<b>YOUR COST IN-NETWORK</b>	<b>YOUR COST OUT-OF-NETWORK</b>
<b>Organ Transplants</b>		
<b>Hospitalization and Physician Care</b>  Services that are pre-authorized by Blue Cross Blue Shield are covered when related to the following human-to-human organ or tissue transplants: heart; lung; heart-lung; liver; kidney; pancreas (when the condition is not treatable by insulin therapy); kidney-pancreas; bone marrow (for leukemia); cornea; and skin and bone.	No cost when received in the Blue Quality Care Transplant network (BQCT)  15% coinsurance after you pay your deductible when services are delivered by a PPO network hospital and physician and not in the BQCT Network	30% coinsurance after you pay your deductible
<b>Organ Procurement from Living and Non-Living Donors</b>  Procurement costs subject to a \$15,000 maximum per transplant	No out-of-pocket cost and no limit on procurement costs when services are received through the BQCT Network  15% coinsurance after you pay your deductible when delivered by a PPO network hospital and physician not in the BQCT Network, plus any amount over the per-transplant \$15,000 maximum	30% coinsurance after you pay your deductible, plus any amount over per-transplant \$15,000 maximum
<b>Transportation, lodging and meals of patient and accompanying family members</b>	Up to \$200 per day, up to \$10,000 per transplant through the BQCT Network  Not covered except through the BQCT Network	Not covered
<b>Lifetime Maximum</b>	Two of each transplant type	

The Blue Quality Care Transplant Network (BQCT) provides broad coverage for organ and tissue transplants through access to a network of top-quality providers. These medical institutions are selected for the BQCT Network based on the expertise of their surgical teams and the state-of-the-art facilities they maintain. Your participation in the BQCT program is completely voluntary. Should you or an eligible dependent need an organ or tissue transplant and wish to participate in the BQCT program, you or your physician should contact Blue Cross Blue Shield. Facility network information is available through Blue Cross Blue Shield. The Plan covers the following expenses associated with transplant surgery, when alternative remedies are not available:

- The use of temporary mechanical equipment, pending the acquisition of a matched human organ;
- Multiple transplants during one operative session;
- Replacement or subsequent transplant; and follow-up expenses for covered services, including immunosuppressant therapy.

The Plan covers *recipient* expenses. A recipient is an individual who undergoes a surgical operation to receive a body organ transplant. Benefits for donor expenses are limited to donors who donate an organ to recipients who are covered under this Plan.

#### **The following special limitations apply to the organ transplant benefit**

The Plan does not cover organ transplant services considered to be experimental or investigational. For details see **What the Plan Does Not Cover** or see **Important Terms** for a definition of *experimental and investigational*.

- If the donor is covered under this Plan, the Plan covers eligible medical expenses incurred by the donor.
- If the donor has no medical insurance coverage, this Plan will cover up to \$15,000 per transplant, or 100% of the charges for care received through the BQCT Network.
- If the donor has medical insurance but donor expenses are excluded under that coverage, this Plan will cover up to \$15,000 per transplant, or 100% for care received through the BQCT network.
  - If the donor has medical insurance, this Plan will coordinate benefits with the primary plan and this Plan will be secondary payor, subject to this Plan's benefit limits.
  - If both the donor and recipient are covered under this Plan, eligible medical expenses incurred by each person are treated separately.
- The Plan covers the reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removing the organ and the hospital's charge for storing or transporting the organ.
- Immunosuppressive therapy is covered.
- Coverage for donor bone or skin grafts to an eligible participant is limited to \$5,000 per donor and \$15,000 per recipient, except if through the BQCT network.

See **What the Plan Does Not Cover** for other limitations or exclusions.

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
<b>Cardiac Rehabilitation</b>		
<b>Outpatient Cardiac Rehabilitation Service</b>	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
Includes Phase II and III of a multi-phasic program for persons with documented cardiovascular disease		
<p>When provided in a hospital or other setting that meets the standards of the Massachusetts Commission of Public Health or comparable health commission in another state, outpatient cardiac rehabilitation services are covered at the same level as other outpatient hospital services.</p> <p>Covered cardiac rehabilitation services include Phases II and III of a multiphasic program for persons with documented cardiovascular disease. This program provides medically necessary treatment designed to restore the patient to optimal physiological health.</p> <ul style="list-style-type: none"> <li>Phase I is the inpatient phase, which begins at the time of the cardiac event and continues through hospital discharge. Benefits for Phase I are covered under the inpatient hospital care portion of the Plan.</li> <li>Phase II is the outpatient convalescent phase that begins after hospital discharge and usually extends for a period of three to 12 weeks.</li> <li>Phase III is the outpatient phase that addresses multiple risk reduction, adjustment to illness and therapeutic exercise. Phase III follows the convalescent phase and usually extends for a period of 12 to 26 weeks.</li> </ul> <p>The Plan does not cover Phase IV benefits, which are designed to maintain rehabilitated cardiovascular health.</p> <p>To be covered, treatment must begin within 26 weeks after the diagnosis of cardiovascular disease or an event related to cardiovascular disease. An event related to cardiovascular disease includes, at a minimum:</p> <ul style="list-style-type: none"> <li><b>Angioplasty;</b></li> <li><b>Cardiovascular surgery; or</b></li> <li><b>Myocardial infarction.</b></li> </ul>		

	<b>YOUR COST IN-NETWORK</b>	<b>YOUR COST OUT-OF-NETWORK</b>
<b>Physical Therapy</b>		
<b>Physical Therapy</b> Must be prescribed by a physician and performed by a licensed physical therapist or physician		
When provided by a free-standing physical therapy provider	\$25 co-pay	30% coinsurance after you pay your deductible
When provided through a rehabilitation hospital on an outpatient basis	\$25 co-pay	30% coinsurance after you pay your deductible
When provided through an acute care hospital on an inpatient or outpatient basis or inpatient through a rehabilitation hospital	15% coinsurance after you pay your deductible	30% coinsurance after you pay your deductible
Covered physical therapy is intended to provide rehabilitation to regain normal movement and strength. The Plan does not cover the following services: recreational or educational therapy; maintenance or palliative rehabilitation therapy; programs due to developmental delay or early intervention; exercise programs; or hippotherapy (exercise on horseback).		
<b>Chiropractic</b>		
<b>Chiropractic Care</b> Coverage is limited to \$500 per calendar year, including office visits and diagnostic testing by a chiropractor	\$25 co-pay and amounts above your calendar-year maximum	30% coinsurance after you pay your deductible and amounts above your calendar-year maximum
To be covered under the Plan, chiropractic services must be rendered by a board-certified chiropractor (DC) and services (including diagnostic services and all other treatments) must be medically necessary to treat an illness or injury. All services performed by a chiropractor are limited to the \$500 calendar-year maximum benefit per person. Chiropractic services are covered under the Plan for covered dependents age 16 and older; no coverage is available for covered dependents under age 16.		

### Alternative Care (Holistic Medicine)

**Acupuncture, Acupressure,  
Homeopathy, Massage  
Therapy**

\$25 co-pay and amounts above  
your calendar year maximum

30% coinsurance after you pay  
your deductible and amounts  
above your calendar year  
maximum

Coverage is limited to \$500 per  
calendar year

Covered providers must be licensed in the state where they are rendering care and carry malpractice insurance. There are times when the Plan will require you to seek a referral from a licensed physician in order to approve treatment.

For the purposes of in-network coverage under this benefit, the providers associated with the Blue Cross Blue Shield Living Healthy Naturally network or with any other Blue Cross Blue Shield PPO provider network are considered PPO preferred providers. In some states network providers may not be available.

You may have to file your own claim to be reimbursed for alternative care benefits.

## Durable Medical Equipment

### Durable Medical Equipment and Prosthetic Appliances

Purchase, or rental up to the purchase price

*Amounts you pay for these services do not count toward your annual out-of-pocket maximum.*

15% coinsurance after you pay your deductible, up to \$5,000 in benefits per calendar year; 50% thereafter

30% coinsurance after you pay your deductible, up to \$5,000 in benefits per calendar year; 50% thereafter

Durable medical equipment must serve a medical purpose and have no other essential value in the absence of an illness or injury. Equipment must meet Blue Cross Blue Shield medical policy guidelines.

Covered services include: non-dental braces; canes; crutches; wheelchairs; artificial limbs and eyes; breast prosthesis and surgical bras following mastectomy; oxygen and equipment for its administration; inhalators; suction machines; respirators; hyperbolic oxygen chambers; and c-pap machines.

Replacement of artificial limbs and eyes limited to prescription change or the appliance must be over five years old. Amounts you pay for durable medical equipment services do not count toward your annual out-of-pocket maximum.

These benefits are provided for the least expensive equipment of its type that meets the patient need. If Blue Cross Blue Shield determines that the patient chose a prosthesis or other equipment that costs more than what the patient needs for his or her medical condition, benefits are provided only for those charges that would have been paid for the least expensive prosthesis or equipment that meets the patient need. In this case the patient must pay the provider's charges that are more than the claim payment.

## Medical and Surgical Supplies

**Medical and Surgical Supply Charges** including: bandages and casts; splints; surgical trays; therapeutic or diagnostic infusion supplies; ostomy; and catheter supplies. (Bandages, splints, casts provided as part of the physician office visit are covered under the office visit co-pay.)

15% coinsurance after you pay your deductible

30% coinsurance after you pay your deductible

## Mental Health/Substance Abuse Care

Modern Assistance Programs, Inc. (MAP) administers inpatient mental health and substance abuse benefits and the Employee Assistance Program (EAP) for the Plan. For the purposes of this inpatient benefit, the network providers are those contracted with MAP. Outpatient mental health and substance abuse providers are those contracted with Blue Cross Blue Shield.

**Before** you receive *inpatient* treatment for mental health or substance abuse treatment, you must call MAP for authorization. MAP counselors are available 24 hours a day, seven days a week. If you are calling outside of normal business hours, ask the answering service to contact the counselor on call.

A trained mental health professional will ask you some questions about your diagnosis. MAP will contact your provider to review your treatment options. You and your provider will generally receive immediate notification of approval (or denial) of your care.

<p><b>Inpatient Mental Health Facility Charges</b> Limited to 60 days per lifetime; care must be pre-authorized by MAP</p>	<p>15% coinsurance, based on MAP negotiated rate, after you pay your deductible</p>	<p>No benefits</p>
<p><b>Inpatient Substance Abuse Facility Charge</b> Limited to the lesser of \$7,500 or two admissions per lifetime; care must be pre-authorized by MAP</p>	<p>15% coinsurance, based on MAP negotiated rate</p>	<p>No benefits</p>
<p><b>Inpatient Professional Charges</b> related to authorized admissions</p>	<p>15% coinsurance, based on MAP negotiated rate, after you pay your deductible</p>	<p>No benefits</p>
<p><b>Outpatient Mental Health Counseling</b> Limited to eight outpatient visits per calendar year</p>	<p>\$25 co-pay when you receive care from a Blue Cross Blue Shield PPO provider</p>	<p>30% coinsurance after you pay your deductible</p>
<p><b>Neuro-Psych Testing</b></p> <p>In-office</p> <p>Hospital outpatient</p>	<p>\$25 co-pay when you receive care from a Blue Cross Blue Shield PPO provider</p> <p>15% coinsurance after you pay your deductible when you receive care from a hospital-based PPO provider</p>	<p>30% coinsurance after you pay your deductible</p> <p>30% coinsurance after you pay your deductible</p>

**You need not get MAP's authorization for:**

- Office visits for mental health counseling with licensed mental health providers (up to Plan limits), and
- Laboratory charges and/or office visits provided for the management of medications.

A network facility is a facility MAP recommends for care and with which MAP has an agreement providing for negotiated rates for Plan participants.

<b>Employee Assistance Program (EAP)</b> (administered by MAP)	100%	No benefits
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The Employee Assistance Program (EAP) provides a qualified and confidential source of help for participants experiencing personal problems. In many instances, you may resolve these problems without the services of the EAP. Sometimes, however, it may be in your best interest to seek outside assistance. EAP benefits are available to you and your eligible dependents at no charge. Any calls you make to the EAP are completely confidential. Under no circumstances will your name or information about your situation be passed onto your employer or the union office.

While the EAP may not solve your problems, it is a reasonable place to start dealing with problems that may be overtaking your life. For several major problems and conditions, skilled and experienced professionals are available to help. You can call the EAP at Modern Assistance Programs, Inc. for a broad range of problems including:

- Stress;
- Anxiety;
- Depression;
- Marital problems;
- Family counseling;
- Financial difficulties; and
- Alcohol and drug abuse.

EAP counselors are available during regular business hours; night and weekend support is available through a counselor on call. The local EAP counselor will meet with you, generally up to three times, to assess your situation and make recommendations. If necessary, the EAP Counselor may refer you to another professional for further assistance. EAP services are entirely voluntary.

**For more information about the EAP, call MAP at (617) 774-0331 or 1-(800) 878-2004**

No pre-existing condition limitations apply to your coverage under this Health and Welfare Plan. This means that you are covered under this Plan for all eligible services as of the date your coverage begins, subject to the limitations and exclusions described in this SPD.