



## Health Insurance Matrix 07/01/09 - 06/30/10

Description	BCBS HMO Blue NE \$1,000	BCBS HMO Blue NE Premier Value	BCBS HMO Blue NE Value Plus	BCBS PPO Blue Care Elect Enhanced Value
<b>Employee Contributions Family</b>	Monthly : \$202.95 Bi-Weekly : \$101.48	Monthly : \$287.03 Bi-Weekly : \$143.52	Monthly : \$338.22 Bi-Weekly : \$169.11	Monthly : \$448.45 Bi-Weekly : \$224.23
<b>Employee Contributions Individual</b>	Monthly : \$76.58 Bi-Weekly : \$38.29	Monthly : \$108.31 Bi-Weekly : \$54.16	Monthly : \$127.64 Bi-Weekly : \$63.82	Monthly : \$169.22 Bi-Weekly : \$84.61
<b>Office Visits</b>	Primary Care Physician: \$25 Specialist: \$25	Primary Care Physician: \$25 Specialist: \$25	Primary Care Physician: \$25 Specialist: \$25	<i>In Network</i> : \$20 <i>Out-of-Network</i> : 20% co-insurance
<b>Wellness Visits</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<i>In Network</i> : <b>\$0</b> <i>Out-of-Network</i> : 20% co-insurance
<b>Periodic Physical Exams</b>	<b>\$0</b> (one per calendar year)	<b>\$0</b> (one per calendar year)	<b>\$0</b> (one per calendar year)	<i>In Network</i> : <b>\$0</b> <i>Out-of-Network</i> : 20% co-insurance (age banded)
<b>Routine OB-GYN Exams</b>	<b>\$0</b> (one per calendar year) No PCP referral required	<b>\$0</b> (one per calendar year) No PCP referral required	<b>\$0</b> (one per calendar year) No PCP referral required	<i>In Network</i> : <b>\$0</b> <i>Out-of-Network</i> : 20% co-insurance (one per calendar year)
<b>Pap Smears</b>	Included as part of the physical exam	Included as part of the physical exam	Included as part of the physical exam	Included as part of the physical exam
<b>Routine Colonoscopy</b>	<b>Covered in Full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
<b>Chiropractic Services</b>	\$25 co-payment Unlimited visits No referral required	\$25 co-payment Unlimited visits No referral required	\$25 co-payment Unlimited visits No referral required	<i>In Network</i> : \$20 <i>Out-of-Network</i> : 20% co-insurance
<b>Laboratory X-Rays</b>	Nothing, after deductible (includes MRI/CT Scans and PET)	No cost (excludes MRI/CT scans, and PET -- \$150 co-payment)	No cost (includes MRI/CT Scans and PET)	<i>In Network</i> : No cost (includes MRI/CT scans, and PET) <i>Out-of-Network</i> : 20% co-insurance (excludes MRI/CT scans, and PET)
<b>Dependent Coverage</b>	Recent Mass. State mandates now apply to all healthcare carriers: By IRS definition, 2 years beyond losing dependent status up to age 26	Recent Mass. State mandates now apply to all healthcare carriers: By IRS definition, 2 years beyond losing dependent status up to age 26	Recent Mass. State mandates now apply to all healthcare carriers: By IRS definition, 2 years beyond losing dependent status up to age 26	Recent Mass. State mandates now apply to all healthcare carriers: By IRS definition, 2 years beyond losing dependent status up to age 26
<b>Emergency Room Visits</b>	\$100 co-payment No deductible (waived if admitted or for observation)	\$100 co-payment (waived if admitted or for observation)	\$100 co-payment (waived if admitted or for observation)	<i>In Network</i> : \$75/visit (waived if admitted or for observation stay) <i>Out-of-Network</i> : \$75/visit, no deductible (waived if admitted or for observation stay)



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<b>Mental Health Counseling</b>	<p>\$25 co-payment - No referral required</p> <p>Biologically based conditions - Unlimited visits</p> <p>Non-biologically based conditions - 24 visits per calendar year</p>	<p>\$25 co-payment - No referral required</p> <p>Biologically based conditions - Unlimited visits</p> <p>Non-biologically based conditions - 24 visits per calendar year</p>	<p>\$25 co-payment - No referral required</p> <p>Biologically based conditions - Unlimited visits</p> <p>Non-biologically based conditions - 24 visits per calendar year</p>	<p><i>In Network</i>: \$20 co-payment - No referral required <i>Out-of-Network</i>: 20% co-insurance</p> <p>Biologically based conditions <i>In Network</i>: \$500/admission <i>Out-of-Network</i>: 20% co-insurance</p> <p>Non-biologically based conditions - 24 visits per calendar year <i>In Network</i>: \$20/visit <i>Out-of-Network</i>: 20% co-insurance</p>
<b>Doctor Selection</b>	HMO Blue Network in all six New England States	HMO Blue Network in all six New England States	HMO Blue Network in all six New England States	<i>In Network</i> : Preferred Provider <i>Out-of-Network</i> : All Others
<b>Pre-Existing Condition</b>	No restriction	No restriction	No restriction	No restriction
<b>Out-of-Area Emergency Care</b>	If you cannot call your PCP, seek treatment at the nearest appropriate health care facility	If you cannot call your PCP, seek treatment at the nearest appropriate health care facility	If you cannot call your PCP, seek treatment at the nearest appropriate health care facility	Seek treatment at the nearest appropriate health care facility
<b>Non-Emergency Hospital Admission</b>	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered
<b>Prescription Drugs <i>Retail</i> (Any participating pharmacy)</b>	\$15 - Tier 1 \$30 - Tier 2 \$50 - Tier 3	\$15 - Tier 1 \$30 - Tier 2 \$50 - Tier 3	\$15 - Tier 1 \$30 - Tier 2 \$50 - Tier 3	\$15 - Tier 1 \$30 - Tier 2 \$50 - Tier 3
<b>Prescription Drugs <i>Mail Order</i> (Through Express Scripts) - 90-Day Supply</b>	\$30 - Tier 1 \$60 - Tier 2 \$100 - Tier 3	\$30 - Tier 1 \$60 - Tier 2 \$100 - Tier 3	\$30 - Tier 1 \$60 - Tier 2 \$100 - Tier 3	\$15 - Tier 1 \$30 - Tier 2 \$50 - Tier 3
<b>Dental Care, Routine Exams, Cleaning</b>	N/A	N/A	N/A	N/A



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<b>Dental Coverage for Dependent Children under 12 Years</b>	<p>One complete oral exam. Every 6 months thereafter: Oral exam, one cleaning, one fluoride treatment, bitewing x-rays. No referral is needed from child's PCP.</p> <p>Services in Mass. Must be provided by a dentist who has an agreement with BCBS.</p> <p>Services outside of Mass. require payment and submission of claim for reimbursement at dentist's actual charge or 90% of Dental Prevailing Health Care Charge, whichever is less.</p>	<p>One complete oral exam. Every 6 months thereafter: Oral exam, one cleaning, one fluoride treatment, bitewing x-rays. No referral is needed from child's PCP.</p> <p>Services in Mass. Must be provided by a dentist who has an agreement with BCBS.</p> <p>Services outside of Mass. require payment and submission of claim for reimbursement at dentist's actual charge or 90% of Dental Prevailing Health Care Charge, whichever is less.</p>	<p>One complete oral exam. Every 6 months thereafter: Oral exam, one cleaning, one fluoride treatment, bitewing x-rays. No referral is needed from child's PCP.</p> <p>Services in Mass. Must be provided by a dentist who has an agreement with BCBS.</p> <p>Services outside of Mass. require payment and submission of claim for reimbursement at dentist's actual charge or 90% of Dental Prevailing Health Care Charge, whichever is less.</p>	N/A
<b>Calendar Year Deductibles</b>	<p>For some services, you must meet a deductible before services are provided: \$1,000 for each member, or \$2,000 for all family members covered under the same membership</p>	<p>\$1,000 deductible for each member, or \$2,500 for all family members covered under the same membership (Applies to Inpatient benefits only)</p>	N/A	<p><i>In Network:</i> N/A <i>Out of Network:</i> \$500 for each member, or \$1,000 for all family members covered under the same membership</p>
<b>Calendar Year Coinsurance Maximum</b>	None	None	None	<p><i>In Network:</i> N/A <i>Out of Network:</i> \$1,000 for each member, or \$2,000 for all family members covered under the same membership</p>
<b>Inpatient Hospital Services - Semi-Private Room</b>	Yes	Yes	Yes	Yes
<b>Inpatient Hospital Services - Private Room</b>	When medically necessary	When medically necessary	When medically necessary	When medically necessary



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<b>Inpatient Hospital Care &amp; Surgery</b>	Nothing after the deductible. \$1,000 deductible for each member, or \$2,000 for all family members covered under the same membership	\$1,000 deductible for each family member, or \$2,500 for all family members covered under the same membership (Applies to Inpatient benefits only)	\$250 co-payment	<i>In Network</i> : \$500/admission <i>Out-of-Network</i> : 20% co-insurance  Rehab Hospital Care <i>In Network</i> : Nothing <i>Out-of-Network</i> : 20% co-insurance  Skilled Nursing Facility <i>In Network</i> : Nothing <i>Out-of-Network</i> : 20% co-insurance
<b>Outpatient (Day) Surgery</b>	100% after deductible	\$250 co-pay	\$250 co-pay	<i>In Network</i> : \$250/admission <i>Out-of-Network</i> : 20% co-insurance
<b>Lifetime Maximum (Catastrophic Illness)</b>	None	None	None	None
<b>Optical</b>	Vision Exam - One per 24 months, no PCP referral required 25% discount on frames and lenses 20% discount on daily wear contact lenses  25% off laser vision correction at participating Davis Vision Providers (over 600 in New England)	Vision Exam - One per 24 months, no PCP referral required 25% discount on frames and lenses 20% discount on daily wear contact lenses  25% off laser vision correction at participating Davis Vision Providers (over 600 in New England)	Vision Exam - One per 24 months, no PCP referral required 25% discount on frames and lenses 20% discount on daily wear contact lenses  25% off laser vision correction at participating Davis Vision Providers (over 600 in New England)	Vision Exam - One per 24 months 25% discount on frames and lenses 20% discount on daily wear contact lenses  25% off laser vision correction at participating Davis Vision Providers (over 600 in New England)
<b>Diabetic Equipment</b>	Glucometers when medically necessary. Insulin injection pens, injectable insulin, disposable syringes and needles. Materials to test for the presence of sugar including blood glucose monitoring strips, ketone strips, lancets, urine glucose testing strips, normal, low, and high calibrator solution/chips, dextrostik or glucose test strips, and insulin infusion pumps and related pump supplies.	Glucometers when medically necessary. Insulin injection pens, injectable insulin, disposable syringes and needles. Materials to test for the presence of sugar including blood glucose monitoring strips, ketone strips, lancets, urine glucose testing strips, normal, low, and high calibrator solution/chips, dextrostik or glucose test strips, and insulin infusion pumps and related pump supplies.	Glucometers when medically necessary. Insulin injection pens, injectable insulin, disposable syringes and needles. Materials to test for the presence of sugar including blood glucose monitoring strips, ketone strips, lancets, urine glucose testing strips, normal, low, and high calibrator solution/chips, dextrostik or glucose test strips, and insulin infusion pumps and related pump supplies.	Glucometers when medically necessary. Insulin injection pens, injectable insulin, disposable syringes and needles. Materials to test for the presence of sugar including blood glucose monitoring strips, ketone strips, lancets, urine glucose testing strips, normal, low, and high calibrator solution/chips, dextrostik or glucose test strips, and insulin infusion pumps and related pump supplies.



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<b>Wellness Plans</b>	<p><u>Weight Loss Benefit</u>: \$150 per year per individual/family</p> <p><u>Fitness Benefit</u>: \$150 per year per individual/family</p> <p><u>Wellness Programs Medical Nutrition</u></p> <p><u>Therapy Benefit</u>: No charge (1-on-1 nutrition counseling for medically necessary conditions provided by a Plan physician)</p> <p><u>Appalachian Mountain Club</u>: 20% discount</p> <p><u>Living Healthy Naturally</u></p> <p><u>Complementary Alternative Medicine (CAM)</u>: 10%-30% discounts on services such as massage therapy, acupuncture, naturopathic medicine, pilates, personal training, yoga, tai chi, gi going, and mind-body therapy</p> <p><u>Safety Products</u>: 20% discount from The Catalog for Safe Beginnings</p> <p><u>Living Healthy Smoke Free</u>: 1-800-TRY-TO-STOP</p> <p><u>Living Healthy Babies</u>: Program to help women prepare for a healthy pregnancy</p>	<p><u>Weight Loss Benefit</u>: \$150 per year per individual/family</p> <p><u>Fitness Benefit</u>: \$150 per year per individual/family</p> <p><u>Wellness Programs Medical Nutrition</u></p> <p><u>Therapy Benefit</u>: No charge (1-on-1 nutrition counseling for medically necessary conditions provided by a Plan physician)</p> <p><u>Appalachian Mountain Club</u>: 20% discount</p> <p><u>Living Healthy Naturally</u></p> <p><u>Complementary Alternative Medicine (CAM)</u>: 10%-30% discounts on services such as massage therapy, acupuncture, naturopathic medicine, pilates, personal training, yoga, tai chi, gi going, and mind-body therapy</p> <p><u>Safety Products</u>: 20% discount from The Catalog for Safe Beginnings</p> <p><u>Living Healthy Smoke Free</u>: 1-800-TRY-TO-STOP</p> <p><u>Living Healthy Babies</u>: Program to help women prepare for a healthy pregnancy</p>	<p><u>Weight Loss Benefit</u>: \$150 per year per individual/family</p> <p><u>Fitness Benefit</u>: \$150 per year per individual/family</p> <p><u>Wellness Programs Medical Nutrition</u></p> <p><u>Therapy Benefit</u>: No charge (1-on-1 nutrition counseling for medically necessary conditions provided by a Plan physician)</p> <p><u>Appalachian Mountain Club</u>: 20% discount</p> <p><u>Living Healthy Naturally</u></p> <p><u>Complementary Alternative Medicine (CAM)</u>: 10%-30% discounts on services such as massage therapy, acupuncture, naturopathic medicine, pilates, personal training, yoga, tai chi, gi going, and mind-body therapy</p> <p><u>Safety Products</u>: 20% discount from The Catalog for Safe Beginnings</p> <p><u>Living Healthy Smoke Free</u>: 1-800-TRY-TO-STOP</p> <p><u>Living Healthy Babies</u>: Program to help women prepare for a healthy pregnancy</p>	<p><u>Weight Loss Benefit</u>: \$150 per year per individual/family</p> <p><u>Fitness Benefit</u>: \$150 per year per individual/family</p> <p><u>Wellness Programs Medical Nutrition</u></p> <p><u>Therapy Benefit</u>: No charge (1-on-1 nutrition counseling for medically necessary conditions provided by a Plan physician)</p> <p><u>Appalachian Mountain Club</u>: 20% discount</p> <p><u>Living Healthy Naturally</u></p> <p><u>Complementary Alternative Medicine (CAM)</u>: 10%-30% discounts on services such as massage therapy, acupuncture, naturopathic medicine, pilates, personal training, yoga, tai chi, gi going, and mind-body therapy</p> <p><u>Safety Products</u>: 20% discount from The Catalog for Safe Beginnings</p> <p><u>Living Healthy Smoke Free</u>: 1-800-TRY-TO-STOP</p> <p><u>Living Healthy Babies</u>: Program to help women prepare for a healthy pregnancy</p>



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<b>Unique Features</b>	<p><u>On Line Tools</u>: aHealthyME!, My Wellbeing, MyBlueHealth  <u>Allergy Injections Only</u>: Nothing  <u>Out-of-Pocket Maximum</u>: \$1,000 for a member and \$2,000 for all family members covered under the same membership. Only co-payments for ambulatory surgery admissions and emergency room services will apply  <u>Speech, Hearing, and Language Disorder Treatment</u>: \$25 co-payment - no limit  <u>Short Term Rehabilitation Therapy (Physical and Occupational)</u>: \$25 co-payment - Covered up to 60 visits per calendar year</p>	<p><u>On Line Tools</u>: aHealthyME!, My Wellbeing, MyBlueHealth  <u>Allergy Injections Only</u>: Nothing  <u>Out-of-Pocket Maximum</u>: \$1,000 for a member and \$2,000 for all family members covered under the same membership. Only co-payments for ambulatory surgery admissions and emergency room services will apply  <u>Speech, Hearing, and Language Disorder Treatment</u>: \$25 co-payment - no limit  <u>Short Term Rehabilitation Therapy (Physical and Occupational)</u>: \$25 co-payment - Covered up to 60 visits per calendar year</p>	<p><u>On Line Tools</u>: aHealthyME!, My Wellbeing, MyBlueHealth  <u>Allergy Injections Only</u>: Nothing  <u>Out-of-Pocket Maximum</u>: \$1,000 for a member and \$2,000 for all family members covered under the same membership. Only co-payments for ambulatory surgery admissions and emergency room services will apply  <u>Speech, Hearing, and Language Disorder Treatment</u>: \$25 co-payment - no limit  <u>Short Term Rehabilitation Therapy (Physical and Occupational)</u>: \$25 co-payment - Covered up to 60 visits per calendar year</p>	<p><u>On Line Tools</u>: aHealthyME!, My Wellbeing, MyBlueHealth  <u>Out-of-Pocket Maximum</u>: \$1,000 for a member and \$2,000 for all family members covered under the same membership. Only co-payments for ambulatory surgery admissions and emergency room services will apply  <u>Speech, Hearing, and Language Disorder Treatment</u>:            In Network: \$20/visit            Out-of-Network: 20% co-insurance            No limit  <u>Short Term Rehabilitation Therapy (Physical and Occupational)</u>:            In Network: \$20/visit            Out-of-Network: 20% co-insurance            Covered up to 100 visits per calendar year</p>
<b>Hospitals</b>	100% of all Massachusetts hospitals	100% of all Massachusetts hospitals	100% of all Massachusetts hospitals	National network of providers and hospitals

*For a complete description of benefits, please refer to your plan certificate (booklet). In case of a discrepancy, the plan certificate will prevail.*