



"WSHG Ratesaver Equivalent"

Network Blue New EnglandSM Value Plus

Total Monthly Premium (Town + Employee)

Single: \$ 761.92 monthly

Family: \$ 2,000.93 monthly

Town of Sherborn

Effective July 1, 2016



To compare medical providers in this network, visit:

www.bluecrossma.com

- Click on Purple Box 'Find a Doctor'
- Click on Yellow Box 'Go to Find a Doctor Without Logging In'
- When searching, use the Network: 'HMO Blue New England'



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2014, as part of the Massachusetts Health Care Reform Law.

Your Care

Your Primary Care Provider.

When you enroll in Network Blue New England, you must choose a primary care provider (PCP) who is available to accept you and your family members and participates in our network of providers throughout the New England states. For children, you may designate a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYNs: visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call our Physician Selection Service at **1-800-821-1388**. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care—Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is probably someone affiliated with your PCP's hospital or medical group. You will not need prior authorization or referral to see a Network Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield concerning referrals, and the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review and services requiring referral from your PCP are detailed in your benefit description.

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for copayments and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$2,500** per member (or **\$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** per family).

Emergency Care—Wherever You Are.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a **\$75** copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay.

Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area.

If you're traveling outside your service area and you need urgent or emergency care, go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please see your benefit description for more information.

Dependent Benefits.

This plan covers dependents until the end of the month in which they turn age 26, regardless of their financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost
Outpatient Care	
Emergency room visits	\$75 per visit (waived if admitted or for observation stay)
Well-child care visits	Nothing
Preventive dental care for children under age 12 (one visit each six months)	Nothing
Routine adult physical exams, including related tests	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing
Routine hearing exams	Nothing
Routine vision exams (one per calendar year)	Nothing
Family planning services—office visits	Nothing
Mental health and substance abuse treatment	\$15 per visit
Office visits	\$15 per visit
Chiropractors' office visits	\$15 per visit
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$15 per visit
Speech, hearing, and language disorder treatment—speech therapy	\$15 per visit
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing
Home health care and hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**
Prosthetic devices	20% coinsurance
Surgery and related anesthesia	
<ul style="list-style-type: none"> • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit 	\$15 per visit*** \$125 per admission
Inpatient Care (including maternity care)	
General hospital care (as many days as medically necessary)	\$250 per admission
Chronic disease hospital care (as many days as medically necessary)	\$250 per admission
Mental health and substance abuse facility care (as many days as medically necessary)	\$250 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** Cost share waived for one breast pump per birth.

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Prescription Drug Benefits	Your Cost*
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	\$10 for Tier 1** \$25 for Tier 2 \$45 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	\$20 for Tier 1** \$50 for Tier 2 \$90 for Tier 3

* Cost share waived for certain orally-administered anticancer drugs.

** Cost share waived for birth control.

Get the Most from Your Plan.

Visit us at www.bluecrossma.com/membercentral or call **1-800-782-3675** to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

<p>Wellness Participation Program Reimbursement for a membership at a health club or for fitness classes This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)</p>	\$150 per calendar year per policy
<p>Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)</p>	\$150 per calendar year per policy
Blue Care Line SM —A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at www.bluecrossma.com.

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?

Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids for members over age 21; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

Please note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.