



"Traditional PPO"

Blue Care Elect PreferredSM (PPO)

Includes Out of Network (OON) Deductible Only

Total Monthly Premium (Town + Employee)

Single: \$ 944.79 monthly

Family: \$ 2,481.14 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: 'Preferred Blue PPO'

Your Choice

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your “in-network” benefits. You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your “out-of-network” benefits.

When You Choose Preferred Providers.

Generally, you have full coverage for most hospital, physician, and other provider covered services. And, for some outpatient services, you pay a **\$15** copayment for each covered visit. The **\$15** copayment does not apply to preventive care services.

Please note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you’re still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
- Call our Physician Selection Service at **1-800-821-1388**.

When You Choose Non-Preferred Providers.

For some covered services, you must meet a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 each year. Your deductible is **\$250** per member (or **\$500** per family). After you have met your deductible, you pay **20 percent** coinsurance for most out-of-network covered services. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider’s actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum.

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

Emergency Room Services.

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 **\$50** copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. There is no deductible for these services.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. Information concerning Utilization Review is detailed in your benefit description and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

This plan covers dependents until the end of the calendar 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

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Calendar-year deductible	None	\$250 per member \$500 per family
Calendar-year out-of-pocket maximum	\$2,500 per member/\$5,000 per family for in-network and out-of-network services combined	
Covered Services		
Preventive Care Well-child care exams, including related tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year from age 3 through age 18 	Nothing	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing	20% coinsurance after deductible
Routine vision exams (one per calendar year)	Nothing	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Other Outpatient Care Emergency room visits	\$50 per visit (waived if admitted or for observation stay)	\$50 per visit, no deductible (waived if admitted or for observation stay)
Clinic visits; physicians' and podiatrists' office visits	\$15 per visit	20% coinsurance after deductible
Mental health or substance abuse treatment	\$15 per visit	20% coinsurance after deductible
Chiropractors' office visits	\$15 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$15 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$15 per visit	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, including MRIs, CT scans, PET scans and nuclear cardiac imaging tests	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Prosthetic devices	20% coinsurance	40% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance after deductible**
Surgery and related anesthesia: <ul style="list-style-type: none"> • Office and health center services • Hospital and other day surgical facility services 	\$15 per visit*** Nothing	20% coinsurance after deductible 20% coinsurance after deductible

* 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.

** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).

*** 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.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% coinsurance after deductible
Prescription Drug Benefits*		
Calendar-year out-of-pocket maximum	\$1,000 per member \$2,000 per family	None
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	\$10 for Tier 1** \$20 for Tier 2 \$35 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	\$20 for Tier 1** \$40 for Tier 2 \$70 for Tier 3	Not covered

* 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.

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.)	\$150 per calendar year per policy
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.)	\$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. The 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.

2/4/2016 PPO Plans

**Town of Sherborn
HEALTH PLAN COMPARISON CHART July 1, 2016**

	MIIA	HARVARD PILGRIM
	Blue Care Elect PPO In Network benefits	HPHC PPO In-Network Benefits
BENEFIT	You Pay	YOU PAY
Lifetime Benefit Maximum	None	None
Deductible	None In Network Care \$250/ \$500 out of network	None In-Network \$100/ \$200 out of network
Out-of-Pocket (OOP) Maximum - If applicable, once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for remainder of plan year.	\$2,500 Individual \$5,000 Family per plan year... \$1,000 Individual \$2,000 Family RX limit	\$2,000 Individual \$4,000 Family per plan year ...\$2,000 Individual \$4,000 Family Rx limit
General Hospital/ Mental Health admissions	Nothing	Nothing
OUTPATIENT		
Emergency Room Visits for Emergency or Accident Care	\$ 50 copay	\$ 40 copay
Outpatient Surgery in a Day Surgery facility or Hospital	Nothing	Nothing
CT, MRI and Pet Scans	Nothing	Nothing
Physical Therapy	\$15 copay per visit (up to 100 visits per calendar year)	\$ 5 copay (short-term); up to 90 consecutive days per condition
Office Visits Primary Care Physician	\$15 copay per visit	\$ 5 copay per visit
Preventive OV - PCP	Nothing	Nothing

Town of Sherborn

HEALTH PLAN COMPARISON CHART July 1, 2016

2/4/2016 PPO Plans

	MIIA	HARVARD PILGRIM
	Blue Care Elect PPO In Network benefits	HPHC PPO In-Network Benefits
BENEFIT	You Pay	YOU PAY
Medical Care/Mental Health Care/Substance Abuse Care (<i>Mental Health copays excluded from OOP max</i>)	\$15 copay per visit	\$ 5 copay per visit
Office Visits Specialist	\$15 copay per visit	\$ 5 copay per visit
OB/GYN	\$15 copay per visit	\$ 5 copay per visit
Diagnostic X-ray and Lab	Nothing	Nothing
Routine Vision Exam	Nothing	\$ 5 copay per visit; one visit per calendar year. \$0 copay for children under 5 years of age
Dental Services	NOT COVERED	Children under age 14 - Preventative dental services. All other members \$5 co-pay for extractions of impacted teeth and initial emergency treatment
OTHER FEATURES		
Hospice Care	Nothing	Nothing
Durable Medical Equipment	20% Coinsurance	20% of HPHC cost

2/4/2016 PPO Plans

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	MIIA	HARVARD PILGRIM
	Blue Care Elect PPO In Network benefits	HPHC PPO In-Network Benefits
BENEFIT	You Pay	YOU PAY
Chiropractor Visits <i>(copays excluded from OOP max)</i>	\$15 copay per visit	\$35 copay per visit 12 visit maximum per calendar year
Prescription Drugs <i>(Inpatient drugs paid in full)</i>	Retail Pharmacy Tier 1: \$10.00 copay Tier 2: \$20.00 copay Tier 3: \$ 35.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$ 40.00 copay Tier 3: \$ 70.00 copay	Retail Pharmacy: Tier 1: \$5.00 copay Tier 2: \$ 10.00 copay Tier 3: \$ 25.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$ 10.00 copay Tier 2: \$ 20.00 copay Tier 3: \$ 75.0 copay
Fitness Benefit		Reimbursement
	Up to \$150 reimbursement per subscriber toward membership at health club, fitness facility or gym per calendar year. Up to \$150 reimbursement per subscriber toward Weight Watchers or hospital based weight loss program per calendar year.	Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®