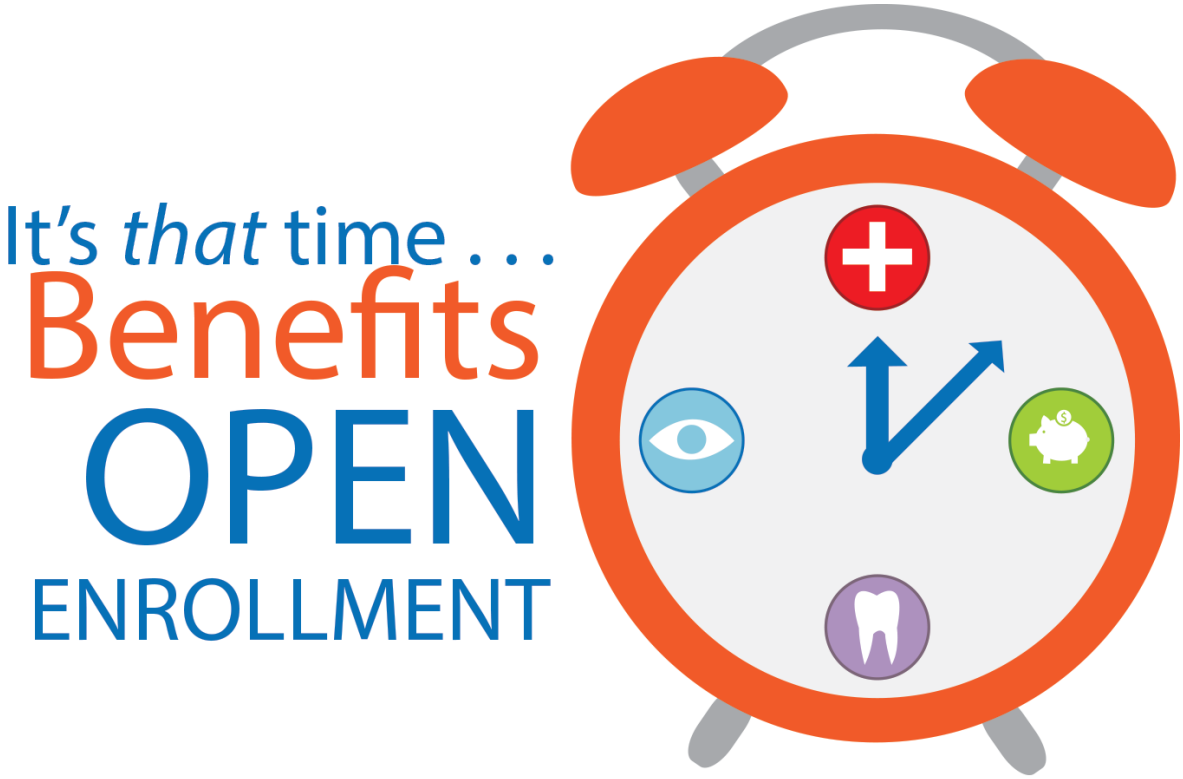
OPEN ENROLLMENT

Guide to Employee Benefits

FY 2025



Deadline for all changes is May 15, 2024 at 4:30 PM

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TOWN OF BOURNE

Human Resource Director

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April 1, 2024

OPEN ENROLLMENT NOTICE
FISCAL YEAR 2025

COVERAGE PERIOD: JULY 2024 – JUNE 2025
WITHHOLDING PERIOD: JUNE 2024 – MAY 2025
BENEFIT CHANGES ALLOWED THRU MAY 15TH

Open enrollment is a once a year period when you can sign up for health and dental insurance coverage if you did not enroll when you were first eligible, previously opted out, or if you need to add a spouse or dependent to your plan or change plans.

IF YOU WISH TO KEEP YOUR CURRENT COVERAGE, NO ACTION IS NEEDED.

Any eligible employee/retiree who chooses to enroll or change their current health plan must complete and return enrollment forms directly to the Human Resource Office no later than 4:30PM on Wednesday, May 15, 2024.

Notable Changes:
There are no plan design changes to the Town's medical plans for FY2025. Health and dental premiums did not change for this year. You will notice a change in the number of payments made this year. If you currently pay on a 52 week/year schedule this is being reduced to a 48 week schedule. We will pay for health, dental, life and vision insurances the first four (4) weeks of every month. On months with a 5th week pay period, health, dental, life and vision deductions will not be taken. This will occur a few times throughout the year. If you are a school employee on a 42 or 39 week pay schedule with benefits, no changes will be made to your deduction schedule.

Plan summaries, enrollment forms, and rate sheets are located at the employee website:

www.townofbourne.com/employees.

Supporting documentation (i.e. marriage certificate and/or birth certificate) is required for all new enrollees.

If you should have any questions, please feel free to contact the Human Resource Office.

Town of Bourne
Insurance Rates
Effective July 1, 2024
(0% Increase Health, 0% Increase Dental)

ACTIVE EMPLOYEES

	Employee Weekly Share 48 Pays*	Employee Weekly Share 42 Pays (ESP)	Employee Weekly Share 39 Pays (Bus Drivers)	Employee Monthly Share (25%)	Full Cost Premium (100%)
BLUE CARE ELECT - PPO					
IND	$ 68.91	$ 78.75	$ 84.81	$ 275.63	$ 1,102.53
FAMILY	$ 165.47	$ 189.10	$ 203.65	$ 661.86	$ 2,647.43
NETWORK BLUE - HMO					
IND	$ 58.79	$ 67.19	$ 72.36	$ 235.16	$ 940.63
FAMILY	$ 140.87	$ 160.99	$ 173.37	$ 563.46	$ 2,253.85
DENTAL					
IND	$ 2.47	$ 2.82	$ 3.04	$ 9.88	$ 39.52
FAMILY	$ 6.62	$ 7.57	$ 8.15	$ 26.49	$ 105.95

EYEMED				Employee Monthly Share (100%)	NA
IND	$ 1.75	$ 2.00	$ 2.15	$ 6.99	
FAMILY	$ 5.14	$ 5.88	$ 6.33	$ 20.57	

BASIC LIFE INSURANCE - $10,000 Term Life Policy				Employee Monthly Share (50%)	Full Cost Premium (50%)
Active Employees	$ 0.90	$ 1.03	$ 1.11	3.60	**$ 7.20**

RETIREES - COUNTY

BLUE CARE ELECT - PPO				Retiree Monthly Share (25%)	Full Cost Premium (100%)
IND	**N/A**	**N/A**	**N/A**	$ 275.63	$ 1,102.53
FAMILY	**N/A**	**N/A**	**N/A**	$ 661.86	$ 2,647.43
NETWORK BLUE - HMO					
IND	**N/A**	**N/A**	**N/A**	$ 235.16	$ 940.63
FAMILY	**N/A**	**N/A**	**N/A**	$ 563.46	$ 2,253.85
		January 2024 - December 2024			
MEDEX II	**N/A**	**N/A**	**N/A**	$ 53.46	$ 213.84
BLUE MEDICARE RX	**N/A**	**N/A**	**N/A**	$ 45.11	$ 180.45
TOTAL				**$ 98.57**	**$ 394.29**
SUBSIDIZED RATE* **					**$ 361.09**
		January 2025 - December 2025			
MEDEX II	**N/A**	**N/A**	**N/A**	$ -	
BLUE MEDICARE RX	**N/A**	**N/A**	**N/A**	$ -	
TOTAL				**$ -**	**$ -**
SUBSIDIZED RATE* **					
DENTAL					
IND	**N/A**	**N/A**	**N/A**	$ 9.88	$ 39.52
FAMILY	**N/A**	**N/A**	**N/A**	$ 26.49	$ 105.95

BASIC LIFE INSURANCE - $5,000 Term Life Policy				Employee Monthly Share (50%)	Full Cost Premium (50%)
Retirees	NA	NA	NA	1.80	**$ 3.60**

***Effective 7/1/2024 Coverage (6/5/2024 Payroll Check) - amounts will be withheld from the first 4 payroll checks each month. No Deductions will be withheld from the 5th payroll check of the month if applicable.**

Medical Insurance

The Town of Bourne offers the option between two health plans to active employees and retirees under the age of 65.

Blue Cross Blue Shield

- PPO (Blue Care Elect)
- HMO (Network Blue)

What are the general differences between an HMO and a PPO?

HMO

- Traditionally lower cost
- Primary Care Physician & referrals to specialized care may be required
- Restricted to in-network medical services, no coverage out of network

PPO

- Traditionally higher cost
- Out of network services available at a higher cost

Blue365

Check out premier health and wellness discounts at
https://www.blue365deals.com/

How do I make an informed decision?

The next few pages will provide a summary of the plan benefits. The carrier documents, provided through Blue Cross Blue Shield, are the only documents that coverage is based on and can be accessed through the contact information at the end of this guide.

Both plans include services that cover transgender healthcare needs, including gender-affirming surgical procedures, hormone therapy, mental health care, and all related medical visits and laboratory services.

BLUE CARE ELECT $250 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

Town of Bourne

Plan-Year Deductible: $250/$750

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

Download the app, or create an account at **bluecrossma.org.**

Where you get care can impact what you pay for care.

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.
As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the preferred general hospitals listed in this Summary of Benefits, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital (not listed in this Summary of Benefits for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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

YOUR CHOICE

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$250** per member (or **$750** per family) for in-network and out-of-network services combined.

When You Choose Preferred Providers
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. See the charts for your cost share.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive inpatient services at or by "higher cost share hospitals," even if your preferred provider refers you. See the chart for your cost share.

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 are referred to 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.

Higher Cost Share Hospitals
Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- **Baystate Medical Center**
- **Boston Children's Hospital**
- **Brigham and Women's Hospital**
- **Cape Cod Hospital**
- **Dana-Farber Cancer Institute**
- **Fairview Hospital**
- **Massachusetts General Hospital**
- **UMass Memorial Medical Center**

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost share may apply.

How to Find a Preferred Provider
To find a preferred provider:

- Look up a provider on Find a Doctor at **bluecrossma.com/findadoctor**. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**

When You Choose Non-Preferred Providers
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. See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield 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 plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical and prescription drug benefits are $6,350 per member (or $12,700 per family) for in-network services and $1,000 per member (or $2,000 per family) for out-of-network services.

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 copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

Utilization Review Requirements
Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

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

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: • Ten 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 for age 3 and older	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$100 per visit, no deductible (waived if admitted or for an observation stay)	$100 per visit, no deductible (waived if admitted or for an observation stay)
Office or health center visits, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit, no deductible $35 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Mental health or substance use treatment	$20 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the in-network designated telehealth vendor	Same as in-person visit $20 per visit, no deductible	Same as in-person visit Only applicable in-network
Chiropractors' office visits	$20 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	$35 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**	40% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible	40% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit***, no deductible $35 per visit***, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care) in:		
• Other general hospitals (as many days as medically necessary) • In-network higher cost share hospitals (as many days as medically necessary)	$300 per admission after deductible† $700 per admission after deductible†	20% coinsurance after deductible Only applicable in-network
Chronic disease hospital care (as many days as medically necessary)	$300 per admission after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$300 per admission after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing 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, including supplies (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.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible $10 for Tier 1 $25 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible $20 for Tier 1 $50 for Tier 2 $110 for Tier 3	Not covered

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived or reduced for certain covered drugs and supplies.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	$150 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see https://www.townofbourne.com/employees/pages/blue-cross-blue-shield-medicaldental. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 member / $750 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, prescription drugs; emergency room.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,350 member / $12,700 family in-network; $1,000 member / $2,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care; a telehealth cost share may be applicable
	Specialist visit	$35 / visit; $20 / chiropractor visit; $35 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; includes physician assistant or nurse practitioner designated as specialty care; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	$100	20% coinsurance	Deductible applies first; copayment applies per category of test / day; pre-authorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or $50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$50 / retail supply or $110 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	20% coinsurance	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit; deductible does not apply	$100 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$35 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 / admission; $700 / admission for certain hospitals	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$300 / admission; $700 / admission for certain hospitals	20% coinsurance	Deductible applies first; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$300 / admission; $700 / admission for certain hospitals	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first except for in-network outpatient services; limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$20 / visit	20% coinsurance	Deductible applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth, including supplies (20% coinsurance for out-of-network)
	Hospice services	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% coinsurance for members with a cleft palate / cleft lip condition	Deductible applies first for out-of-network; limited to members under age 18

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam per calendar year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	$250
■ Delivery fee copay	$0
■ Facility fee copay	$300
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$610**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$250
■ Specialist visit copay	$35
■ Primary care visit copay	$20
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	$250
■ Specialist visit copay	$35
■ Emergency room copay	$100
■ Ambulance services copay	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from some preferred general hospitals, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

NETWORK BLUE® NEW ENGLAND $250 DEDUCTIBLE

WITH HOSPITAL CHOICE COST SHARING

Town of Bourne

Plan-Year Deductible: $250/$750

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

Download the app, or create an account at **bluecrossma.org.**

Where you get care can impact what you pay for care.

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.
As a member in this plan, you will pay different levels of cost share (such as copayments and/or coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from any of the network general hospitals listed in this Summary of Benefits, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital (not listed in this Summary of Benefits) for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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YOUR CARE

Your Primary Care Provider (PCP)
When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**; consult Find a Doctor at **bluecrossma.com/findadoctor**; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school the doctor attended, and whether there are languages other than English spoken in the office.

Referrals
Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see an HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Cost Share
This plan has two levels of hospital benefits. You will pay a higher cost share when you receive inpatient services at or by "higher cost share hospitals," even if your PCP refers you. See the chart for your cost share.

Higher Cost Share Hospitals
Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- **Baystate Medical Center**
- **Boston Children's Hospital**
- **Brigham and Women's Hospital**
- **Cape Cod Hospital**
- **Dana-Farber Cancer Institute**
- **Fairview Hospital**
- **Massachusetts General Hospital**
- **UMass Memorial Medical Center**

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply.

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$250** per member (or **$750** per family).

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical and presciption drug benefits is **$6,350** per member (or **$12,700** 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 copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your benefit description (and riders, if any) for exact coverage details.

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 the service area and you need urgent or emergency care, you should 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. See your benefit description for more information.

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. See your benefit description (and riders, if any) for exact coverage details.

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one per calendar year)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	$100 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit, no deductible $35 per visit, no deductible
Mental health or substance use treatment	$20 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit $20 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year for a member age 16 or older)	$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	$35 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit, no deductible
Diagnostic X-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	$20 per visit***, no deductible $35 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible
Inpatient Care (including maternity care) in:	
• Other general hospitals (as many days as medically necessary) • Higher cost share hospitals (as many days as medically necessary)	$300 per admission after deductible† $700 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	$300 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$300 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing 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.
** Cost share waived for one breast pump per birth, including supplies.
*** 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.
† This cost share applies to mental health admissions in a general hospital.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible $10 for Tier 1 $25 for Tier 2 $50 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible $20 for Tier 1 $50 for Tier 2 $110 for Tier 3

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived or reduced for certain covered drugs and supplies.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	$150 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

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

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see https://www.townofbourne.com/employees/pages/blue-cross-blue-shield-medicaldental. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **bluecrossma.org/sbcglossary** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 member / $750 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, prenatal care, emergency room, prescription drugs, most office visits, mental health visits, and therapy visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,350 member / $12,700 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	A telehealth cost share may be applicable
	Specialist visit	$35 / visit; $20 / chiropractor visit; $35 / acupuncture visit	Not covered	Limited to 20 chiropractor visits for spinal manipulation only per calendar year for members age 16 or older; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	$100	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail supply or $20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or $50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	$50 / retail supply or $110 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived or reduced for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$100 / visit; deductible does not apply	$100 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$35 / visit	$35 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 / admission; $700 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	A telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$300 / admission; $700 / admission for certain hospitals	Not covered	Deductible applies first; pre-authorization / authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Deductible applies first except for prenatal care; cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$300 / admission; $700 / admission for certain hospitals	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Rehabilitation services	$20 / visit for outpatient services; No charge for inpatient services	Not covered	Deductible applies first except for outpatient services; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$20 / visit	Not covered	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Deductible applies first; cost share waived for one breast pump per birth, including supplies
	Hospice services	No charge	Not covered	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care (20 visits for spinal manipulation only per calendar year for members age 16 or older)
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (one exam per calendar year)
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- Weight loss programs ($150 per calendar year per policy)

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Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

■ **The plan's overall deductible**	**$250**
■ **Delivery fee copay**	**$0**
■ **Facility fee copay**	**$300**
■ **Diagnostic tests copay**	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$610**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$250**
■ **Specialist visit copay**	**$35**
■ **Primary care visit copay**	**$20**
■ **Diagnostic tests copay**	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

■ **The plan's overall deductible**	**$250**
■ **Specialist visit copay**	**$35**
■ **Emergency room copay**	**$100**
■ **Ambulance services copay**	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of cost share (such as copayments and coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from some network general hospitals, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.org/hospitalchoice**. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

MASSACHUSETTS

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Complaint forms are available at **hhs.gov**.

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55-1487 (3/24)

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

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Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíiji̧' béésh bee hodíílnih (TTY: **711**).

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55-1493 (6/23)

Interested in doing more with your health coverage?

Did you know Blue Cross Blue Shield offers premier health and wellness discounts on a variety of things like:

* Footwear and Apparel
* Fitness
* Hearing and Vision
* Nutrition
* Personal Care
* Travel

The Deals are always changing & its FREE to join!

All you have to do is log in with your Blue Cross Blue Shield Health Card!

Check it out at the link below!

https://www.blue365deals.com/

Dental and Vision Insurance

Dental

- BCBS Dental Blue

Vision

- EyeMed

How do I make an informed decision?

The following pages provide benefit summaries of the Dental and Vision benefits offered by the Town. EyeMed is not subsidized; it is fully paid for by the employee. Please note that eye exams are covered through your medical plan, not through EyeMed. AFLAC also offers a dental reimbursement program that is outlined later in the guide.

Blue Cross Blue Shield of MA Website: https://www.bluecrossma.org/

EyeMed Website: https://eyemed.com/en-us

Wellness Offerings

Did you know that your Blue Cross Blue Shield plan could get you a $150 Fitness Reimbursement? See the form at the end of this guide for your FY 2025 reimbursement!

Keep your eye out for Elise's HR Newsletter for other wellness things throughout the year.

DENTAL BLUE® PROGRAM 2

(WITH ORTHODONTICS)

Town of Bourne

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

Download the app, or create an account at **bluecrossma.org.**

DENTAL BLUE PROGRAM 2 WITH ORTHODONTICS

For members under age 13, benefits (except for orthodontic services) are covered in full up to the calendar-year benefit maximum and are not subject to the deductible.

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	$50 Per Member/$150 Per Family Calendar-Year Deductible	
Full Coverage	80% Coverage	50% Coverage
$1,500 Per Member Calendar-Year Benefit Maximum		

Diagnostic
- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- Bitewing X-rays twice per calendar year
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams twice per calendar year
- Emergency exams

Preventive
- Routine cleaning, scaling, and polishing of the teeth twice per calendar year
- Fluoride treatment twice per calendar year (members under age 19)
- Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per bicuspid or molar surface each 48 months.
- Space maintainers needed due to premature tooth loss (members under age 19)

Restorative
- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period)
- Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery
- Tooth extraction
- Root removal
- Biopsies

Periodontics (gum and bone)
- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)
- Root canal therapy (permanent teeth, once in a lifetime per tooth)
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- Other endodontic surgery to treat or remove the dental root

Prosthetic Maintenance
- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- Adding teeth to an existing complete or partial denture
- Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Services
- Occlusal adjustments once each 24 months
- Services to treat root sensitivity
- Emergency dental care to treat acute pain or to prevent permanent harm to a member
- General anesthesia when administered in conjunction with covered surgical services

Prosthodontics (teeth replacement)
- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- Adding teeth to an existing bridge
- Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)

Major Restorative (members age 16 or older)
- Crowns, once each 60 months for each tooth
- Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Post and core or crown buildup, once each 60 months for each tooth

Implants (members age 16 or older)
- Single tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars

Orthodontic Benefit Group

Full coverage for members up to age 19
No deductible
- Complete orthodontic exam
- Comprehensive or limited active orthodontic treatment, including appliances

$1,000 Lifetime Benefit Maximum

WELCOME TO DENTAL BLUE,

A COMPREHENSIVE DENTAL PLAN PROVIDING BROAD NETWORK ACCESS TO MEET YOUR DENTAL CARE NEEDS.

Your Dentist
Dental Blue offers a large network of dentists, including participating dentists in Massachusetts and nationwide.

If you would like help choosing a dentist, or already have a dentist and want to know if they participate with your plan, you can call the dentist, look at the current dental provider directory, or call Member Service at the toll-free phone number shown on your Dental Blue ID card. You can also access the online dental provider directory at **bluecrossma.org**.

Your Benefits
The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and benefit maximum amounts shown in the chart. **For members under age 13, these benefits (not including orthodontic services) are covered in full up until the calendar-year benefit maximum.** The calendar year begins on January 1 and ends on December 31 of each year. The chart also shows the percentage of costs your plan will pay for covered dental services. Many of the covered services have specific time or age limits.

Pre-Treatment Estimates
If your dentist expects that your dental treatment will involve covered services that will cost more than $250, Blue Cross Blue Shield recommends that your dentist send a copy of the "treatment plan" to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service. Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year or lifetime benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year or lifetime benefit maximum or eligibility status has changed.)

Multi-Stage Procedures
Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure. You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Dentists Are Paid - Participating Dentists
Dentists that participate with Blue Cross Blue Shield of Massachusetts and nationwide accept the lesser of either the dentist's actual charge or the allowed charge as payment in full for covered services. You pay only your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year or lifetime benefit maximum.

In Massachusetts, benefits are usually only provided when covered services are received from a participating dentist. The exceptions are described in your plan description.

How Dentists Are Paid – Non-participating Dentists Outside of Massachusetts
Benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on the dentist's actual charge or the allowed charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year benefit maximum.

How Orthodontic Benefits Are Paid
Your plan includes orthodontic coverage. The lifetime benefit maximum is not part of your calendar-year benefit maximum; it applies only to orthodontic services. You are responsible for your coinsurance and any charges beyond your lifetime benefit maximum. Benefits are available on your effective date. If your orthodontic treatment began before you were covered under Dental Blue, a monthly fee will be paid for your remaining orthodontic visits until either your treatment is completed or the lifetime benefit maximum is exhausted, whichever comes first.

When Coverage Begins
You are covered, without a waiting period, from the date you enroll in the plan.

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. See your plan description (and riders, if any) for exact coverage details.

Enhanced Dental Benefits
Enhanced Dental Benefits for certain dental care services are available for members who have been diagnosed with qualifying conditions. To learn more about specific conditions included in this benefit, review your plan description (and riders, if any) on MyBlue at **bluecrossma.org**.

If You Have to File a Claim
Participating dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist as long as the claims are received within one year of the completed service.

If you receive care from a non-participating dentist, you will typically need to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service.

After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

If you have a grievance, see your plan description for instructions on how to file a grievance.

Other Information
Coordination of benefits applies to plan members who are covered by another plan for health care expenses. Coordination of benefits ensures that payments from other insurance or health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause, which means that Blue Cross Blue Shield can recover payments if a member has already been paid for the same claim by a third party.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payments only and does not assume financial risk for claims.

March 2024

MASSACHUSETTS

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BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

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If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

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55-1487 (6/22)

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

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Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

001651831

55-1493 (6/22)


eyemed
Go ahead, be choosy
They say variety is the spice of life, and we couldn't agree more. We are happy to offer our members a variety of in-network choices that include independent doctors and 5 of the most preferred national retail chains. Giving you thousands of optometrists, ophthalmologists and opticians to choose from throughout the United States and Puerto Rico.
Wherever you are, we've got you covered. For a complete list of participating providers, visit us at eyemed.com
Private Practitioners
LensCrafters
Pearle Vision
44
sears optical
Target Optical
jcp optical

eyemed

What's in it for me?

Options. It's simple really. We love our members–that's why we are dedicated to helping you see clearly and we've built a network that gives you lots of choices and flexibility. You can choose from independent doctors and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy to use and to save you money. Welcome to EyeMed.

eyemed.com

Benefits Snapshot

	With Us	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	$0 Copay	Up to $50
Frames (Once every 12 months)	$0 Copay; $150 allowance; 80% of charge over $150	Up to $90
Single Vision Lenses (Once every 12 months)	$20 Copay	Up to $42
Or		
Contacts (Once every 12 months)	$0 Copay; $150 allowance; plus balance over $150	Up to $120

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference . . .

85% SAVINGS with us

With Us		Without Insurance**	
Exam	$0 Copay	Exam	$106
Frame	$163 -$150 allowance $13 -$2.60 (20% discount off balance) $10.40	Frame	$163
Lens	$20 Copay $15 UV treatment add-on +$15 Scratch coating add-on $50	Lens	$78 $23 UV treatment add-on +$25 Scratch coating add-on $126
Total	$60.40	Total	$395

Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. **Based on industry averages.

Private Practitioners · LensCrafters · Pearle Vision · sears optical · Target Optical · jcp optical

Town of Bourne

More, for less...

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Hello, Neighbor

- You're on the INSIGHT Network
- For a complete list of providers near you, use our Provider Locator on www.eyemed.com and choose the INSIGHT network or call 1-866-804-0982.
- For Lasik providers, call 1-877-5LASER6 or visit eyemedlasik.com.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$0 Copay	Up to $50
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $150 allowance; 80% of charge over $150	Up to $90
Standard Plastic Lenses		
Single Vision	$20 Copay	Up to $42
Bifocal	$20 Copay	Up to $78
Trifocal	$20 Copay	Up to $130
Standard Progressive Lens	$20 Copay	Up to $140
Premium Progressive Lens△	$40 Copay - $65 Copay	
Tier 1	$40 Copay	Up to $140
Tier 2	$50 Copay	Up to $140
Tier 3	$65 Copay	Up to $140
Tier 4	$20 Copay, 80% of charge less $120 Allowance	Up to $140
Lenticular	$20 Copay	Up to $130
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$0	Up to $26
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating△	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses		
Conventional	$0 Copay; $150 allowance; 15% off retail price over $150	Up to $120
Disposable	$0 Copay; $150 allowance; plus balance over $150	Up to $120
Medically Necessary	$0 copay, Paid in Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

△Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels.

of the six most popular retailers

eyemed

We've got you covered

We understand, everybody is different, so if you prefer an independent doctor or a retail provider with extended evening and weekend hours, there's an option for you. We've built a network to give our members choices. So many choices that we can't fit them all on this page, so visit eyemed.com or scan the QR code with your smartphone to search our complete list of participating providers.

eyemed.com

Locations near 02532 for the InSight network

LENSCRAFTERS
INDEPENDENCE MALL
101 INDEPENDENCE MALL WAY
KINGSTON, MA 02364
781-585-4175

TARGET OPTICAL
79 COMMERCE WAY
SEEKONK, MA 02771
508-336-1199

JCPENNEY OPTICAL
400 BALD HILL RD
WARWICK, RI 02886
401-738-0181

PEARLE VISION
INDEPENDENCE MALL
101 INDEPENDENCE MALL WAY
KINGSTON, MA 02364
781-585-1668

SEARS OPTICAL
CAPE COD MALL
ROUTE 132
HYANNIS, MA 02601
508-790-7352

LENSCRAFTERS
FESTIVAL AT HYANNIS
1070 IYANOUGH RD RTE 132
HYANNIS, MA 02601
508-775-5571

LENSCRAFTERS
DARTMOUTH TOWNE CENTER
382 STATE RD RTE 6
N DARTMOUTH, MA 02747
508-993-1757

PEARLE VISION
PEARLE VISION CENTER
83B FAUNCE CORNER RD
N DARTMOUTH, MA 02747
508-997-6591

SEARS OPTICAL
NORTH DARTMOUTH MALL
100 N DARTMOUTH MALL
N DARTMOUTH, MA 02747
508-979-7256

LENSCRAFTERS
SILVER CITY GALLERIA
2 GALLERIA MALL DR
TAUNTON, MA 02780
508-824-7074

SEE BREEZE OPTICAL
99 MAIN ST
BUZZARDS BAY, MA 02532
508-759-0011

POST OCONNOR & KADRMAS EYE
3119 CRANBERRY HWY STE 3
EAST WAREHAM, MA 02538
508-759-1360

GREGORY T BODRIE OD
PO BOX 532
66 PLEASANT ST
SAGAMORE, MA 02561
508-888-2020

MASS OPTOMETRIC ASSOCIATES
2421 CRANBERRY HWY STE 210
WAREHAM, MA 02571
508-273-0107

BOURNE VISION CONSULTANTS
16 MACARTHUR BLVD
BUZZARDS BAY, MA 02532
508-759-2559

SEE BREEZE OPTICAL
68 TUPPER RD
SANDWICH, MA 02563
508-888-3821

ASSOCIATED EYE SURGEONS
441 ROUTE 130 STE 10
SANDWICH, MA 02563
508-888-8873

OPHTHALMIC CONSULTANTS BOST
282 RTE 130 AND COTUIT RD
SANDWICH, MA 02563
508-833-8222

OPHTHALMIC CONSULTANTS BOST
146 INDUSTRIAL PARK RD
PLYMOUTH, MA 02360
508-833-6000

MASS OPTOMETRIC ASSOCIATES
198 COLONY PLACE RD
PLYMOUTH, MA 02360
508-732-0196

EYE HEALTH SERVICES
32 RESNIK RD STE 2
PLYMOUTH, MA 02360
508-747-6425

MARK E SCHIFFMAN OD
31 TEATICKET HWY RTE 28
EAST FALMOUTH, MA 02536
508-540-9596

POST OCONNOR & KADRMAS EYE
133 FALMOUTH RD
MASHPEE, MA 02649
508-477-7833

BOSTON EYE CARE CONSULTANTS
14 BRAMBLE BUSH DR
FALMOUTH, MA 02540
508-771-6447

ADVANCED EYECARE SPECIALIST
352 MAIN ST UNIT 1
FALMOUTH, MA 02540
508-444-8691

PUBLIC SPECTACLE OPTICIANS
53 COURT ST
PLYMOUTH, MA 02360
508-746-8880

ASSOCIATED EYE SURGEONS
45 RESNIK RD
PLYMOUTH, MA 02360
508-747-4748

DOWLING OPTICAL
1662 FALMOUTH RD
CENTERVILLE, MA 02632
508-771-4422

POST OCONNOR & KADRMAS EYE
40 INDUSTRIAL PARK RD
PLYMOUTH, MA 02360
508-746-8600

ACUVISION EYECARE
16 FAIRHAVEN COMMONS WAY
FAIRHAVEN, MA 02719
508-999-4401

M2EYE
36 CORDAGE PARK CIR STE 108
PLYMOUTH, MA 02360
508-747-3937

EYE HEALTH VISION CENTERS
70 HUTTLESTON AVE
FAIRHAVEN, MA 02719
508-994-2020

DONALD L PASAKARNIS OD
116 TARKILN HILL RD
NEW BEDFORD, MA 02745
508-998-2020

WENDY J LESLIE OD
113 CORPORATION ST
HYANNIS, MA 02601
508-778-9473

EYE SEE QUALITY EYECARE INC
846 ASHLEY BLVD
NEW BEDFORD, MA 02745
508-995-6000

STEPHEN D MORRIS OD
16 MERCHANTS WAY
MIDDLEBORO, MA 02346
508-946-0900

OPTIQUE LTD
16 MERCHANTS WAY
MIDDLEBORO, MA 02346
508-947-6300

LOUIS AGUIAR OD
12 S 6TH ST
NEW BEDFORD, MA 02740
508-992-4046

OPHTHALMIC CONSULTANTS OF B
88 ANSEL HALLET RD
WEST YARMOUTH, MA 02673
508-771-4848

POST OCONNOR & KADRMAS EYE
12 W GROVE ST
MIDDLEBORO, MA 02346
508-946-9301

JOSEPH R GLENNON OD
1212 KEMPTON ST
NEW BEDFORD, MA 02740
508-997-3222

BOSTON UNIVERSITY EYE ASSOC
511 W GROVE ST
MIDDLEBORO, MA 02346
508-947-8868

SAVARD & MOSKOS EYE HEALTH C
511 W GROVE ST STE 101
MIDDLEBORO, MA 02346
508-947-7321

DR PATRICIA VANTOSH OD
27 RAILROAD AVE STE 1
DUXBURY, MA 02332
781-934-6945

EYE HEALTH SERVICES
23 WHITES PATH STE A2D
S YARMOUTH, MA 02664
508-398-6131

EYE HEALTH VISION CENTERS
51 STATE RD
N DARTMOUTH, MA 02747
508-994-1400

Eye exams offered by DPA/DTA or DEA-certified optometrists and ophthamologists. All certifications are verified by and NCQA-accredited credentials verification organization.

Private Practitioners
Range: 0-45 miles

LENSCRAFTERS

PEARLE VISION

sears optical

OPTICAL

jcp optical

EXTERNAL OFFERINGS

Life, Accidental Death, and Disability Insurance

- AFLAC (Life, Accident, Short Term Disability, Cancer Care, more)
- Boston Mutual (Life)

How do I make an informed decision?

These services are completely optional and are not subsidized by the Town (other than a 50% subsidy for $10,000 in life insurance through Boston Mutual). All the above listed services can be paid for through payroll deductions. For additional information, please contact the following sales representatives who work closely with the Town:

AFLAC

Stephen DeBellis

stephen_debellis@us.aflac.com

(617) 512-6731

For information on Boston Mutual subsidized or voluntary life insurance, please contact the Bourne Human Resources Office.

For more information, please visit the following websites:

Boston Mutual: https://www.bostonmutual.com/

AFLAC: https://www.aflac.com

BOURNE NEW HIRE PACKETS

Review the materials & reach out to Stephen M. DeBellis with questions

Weekly Rates

NEW - Life Insurance (Whole, Term & Juvenile Whole)

- *Based on Age, Tobacco Use and Term chosen*
- *Your coverage is portable, which means it goes with you if you change jobs.*
- *No physicals or blood work required by Aflac & rates will never increase*
- *Coverage amounts range from $20,000 and can go up to $500,000*
- ***$25k Term Life plans can be given with NO underwriting needed, if done within 60 days of the new employee's hire date!!!***

Aflac Short Term Disability - *rates based off of:*

- *Annual Pay, Amount of coverage, Benefit periods, Waiting periods and Age*
- ***Benefits pays on top of vacation or sick time and also cover maternity leave***
- ***3 or 6 months of coverage is GUARANTEED to folks who apply (aged 18-64)***
- ***MATERNITY BENEFIT is amazing(plan must be active for 10 months prior to due date & delivery to receive robust MATERNITY payouts)***

Accident Plan

Age	*Individual*	*Individual & Spouse*	*1 Parent Family*	*2 Parent Family*
18-64	**$6.87**	**$9.15**	**$10.62**	**$13.41**

Accident Plan (Aflac Group – CAIC)

(Group - CAIC plans can only be enrolled in, during November)

Aflac PLUS Rider– guaranteed to issue!

Age Groups	*Individual*	*Individual & Spouse*	*1 Parent Family*	*2 Parent Family*
18-29	**$0.72**	**$1.35**	**$1.44**	**$1.74**
30-39	**$1.02**	**$2.01**	**$1.56**	**$2.25**
40-49	**$1.74**	**$3.30**	**$2.10**	**$3.39**
50-64	**$2.97**	**$5.67**	**$3.06**	**$5.70**

The Aflac Plus Rider(MA) can be added to a NEW Hospital plan, a Disability plan or a NEW Accident plan(not the Group plan)

Stephen can be reached on 617-512-6731 or email stephen_debellis@us.aflac.com

Weekly Rates

Hospital Advantage Plan-Preferred–Options 1 & 2 guaranteed to issue!

Preferred	*Individual*	*Individual & Spouse*	*1 Parent Family*	*2 Parent Family*
18-64 - Option 1	**$6.54**	**$9.69**	**$8.85**	**$10.95**
18-64 Options 1 & 2	**$8.10**	**$12.99**	**$11.85**	**$14.79**
18-64 Options 1, 2 & 3	**$9.57**	**$15.69**	**$13.50**	**$17.49**
18-64 Options 1, 2, 3 & 4	**$11.52**	**$19.29**	**$15.54**	**$20.34**

Options 1 & 2 are automatic; but options 3 & 4 require underwriting.

Aflac Cancer Care - Classic

Age	*Individual (+Dependents)*	*Spousal (+Dependents)*
18-64	**$8.94**	**$15.78**

Wellness Benefit are $75/person & Plan protects you against 31 other diseases too
***Plan starts off Diagnosis money as $4K for adults & $8k for kids, grows $500/every year ***

Aflac Cancer Care - Premier

Age	*Individual (+Dependents)*	*Spousal (+Dependents)*
18-64	**$12.18**	**$21.72**

Wellness Benefit are $100/person & Plan protects you against 31 other diseases too
***Plan starts off Diagnosis money as $6K for adults & $12k for kids, grows $500/every year ***

Lump Critical Illness Plan (Aflac Group – CAIC)

(Aflac Groups - CAIC plans can only be enrolled in, during November)

On the Cape we talk about how Cancer affects a lot of people. People also worry about other serious health events occurring like a Stroke, Heart Attack, Major Organ Transplant or Renal Failure(end stage). ***Pricing for this plan is determined by these age groups, which are: 18-29, 30-39, 40-49, 50-59 & 60-69.*** *These events lead to debt and serious financial concern.* ***Aflac's Lump Sum Critical Illness pays you from $10,000 and goes up to $50,000.*** *You choose your payment amount.*

MA - Dental Plans

Age Groups	*Individual*	*Individual & Spouse*	*1 Parent Family*	*2 Parent Family*
Essentials = 18-70	**$5.43**	**$9.57**	**$9.51**	**$13.68**

Name:_____

Contact Phone #:_____ Best time to call _____

Email:_____

Which Bourne Department do you work at:_____

What State is your home address in:_____

Married (circle one please): YES or NO Kids under age 26(how many)_____

❑ **YES, I would like to speak more with our AFLAC representative about:**

- ❑ **Life Insurance**
  (Whole, Term& Juvenile Whole options - no physical/medical testing required) Amounts range from $20k and got up to $500k. Terms are 10, 20 or 30 years.
- ❑ **Aflac Short Term Disability**
  (Pays cash to you for missing work due to sickness, out of work injury or ***maternity****. Pays you on top of sick time!)* ***Ask for VALUE Rider info too!***
- ❑ **Accident Plan – (choose Aflac plan or Aflac Group plan)**
  (Pays cash to you for treatment of an accident or injury on or off the job)
- ❑ **Aflac Cancer Care – Classic OR Premier**
  (Pays premium cash amounts to you for treatments medically or non-medically related to cancer. Kids are covered, until age 26.)
- ❑ **Hospital Advantage –**
  (AFLAC pays cash directly to you for hospital confinements, *and the best thing is that it will pay on top of any other hospital benefits received from other Aflac plans too. Plan covers maternity, ER visits and surgeries. Guaranteed to Issue!*
- ❑ **Aflac PLUS Rider–**
  (Must be added to either an accident, disability or hospital plan)
  (Pays thousands of dollars directly to you to instantly relieve the financial burden of an event, like a ***heart attack, stroke, ms, type 1 diabetes, lyme disease, sudden cardiac arrest and other similar issues****, for you or a family member)*
- ❑ **CAIC - Lump Sum Critical Illness (Aflac Group - Critical Illness – CAIC)**
  (Plan pays $10k up to $50k for a covered Critical Illness, listed in the brochure. We can cover a spouse and child for half of your amount. You choose your benefit amount. You can also add Cancer coverage to this plan for an added cost. Cost is based upon your age at enrollment time.)
- ❑ **Dental – plans have very high yearly maximums. NO NETWORKS!**
  Plan can be paired with your other dental plan, to provide amazing coverage.

*****Checking a box does not obligate you to enroll in any of this coverage - just learn more*****

❑ **NO, I waive my right to participate in any Aflac programs this year.**

Stephen can be reached on 617-512-6731 or email stephen_debellis@us.aflac.com
(you can enroll in person OR by phone with Stephen)

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891-

FAMILY MATTERS. NO MATTER WHAT.®

Basic Life and Accidental Death & Dismemberment (AD&D) Benefit Summary

Designed for the Employees of

Town of Bourne

ELIGIBILITY & BENEFIT FEATURES

Class 1: All Full-time Active Employees working 20 hours

Basic Life and AD&D: $10,000

COST OF COVERAGE

The premium for your coverage is paid by you and your employer.

GUARANTEED ISSUE

No medical questions are required for amounts up to **$10,000** for first time applicants in their initial eligibility period.

REDUCTIONS IN BENEFITS

Your benefit amount will reduce upon retirement to **$5,000** .

* *All insurance benefits shall terminate upon the employee's termination of employment.*

ADDITIONAL FEATURES

Accelerated Death Benefit: This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary. To be eligible, the employee must have at least $10,000 in basic life coverage.

Accidental Death & Dismemberment: Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. An additional death benefit is paid if death is the result of a covered accident.

Portability: If you leave your employer prior to age **60** , the coverage is portable for you, your spouse under age **60** and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or AD&D.

Conversion: Employees have 31 days from the date of termination to convert their basic life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or AD&D.

Waiver of Premium: If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Also Included: Education Benefit, Seat Belt Benefit, and Repatriation of Remains Benefit.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

FAMILY MATTERS. NO MATTER WHAT.®

Voluntary Term Life and Accidental Death & Dismemberment Benefit Summary (Issue Age Pricing)

Designed for the Employees of

Town of Bourne

INSURANCE ELIGIBILITY & BENEFIT FEATURES

All eligible active employees working **20** or more hours per week.

Dependent coverage is available only if the employee elects coverage. Dependents may not be insured if they are confined to a medical facility. If the employee is not actively at work on the effective date of coverage, the insurance will become effective on the date of the employee's return to active employment.

Employee coverage maximum of **$500,000** , sold in increments of **$10,000** . Coverage cannot exceed **5** times base annual salary.

Spouse coverage: **Life and AD&D** maximum of **$100,000** , sold in increments of **$5,000** . Coverage cannot exceed **50** % of employee coverage amount elected.

Child coverage: **Life only** Age 14 days to 1 year: **$1,000**
Age 1 to 26 years: **$10,000**

A spouse or child who is also an employee cannot be insured as a dependent. If both spouses are insured as employees of the same group, their children can be insured as dependents of one spouse only.

COST OF COVERAGE

The premium for your coverage is paid by you.

This plan utilizes Boston Mutual's issue age billing option. Issue age billing means that employees and spouses enroll and are billed based on their age band as of the effective date of coverage. Once enrolled, employees and spouses remain in the age band they were originally issued at with Boston Mutual.

After the initial rate guarantee period, the group is subject to an annual review and possible rate changes.

GUARANTEED ISSUE

No medical underwriting will be required unless you apply for coverage over the Guaranteed Issue amount, apply beyond the initial 31 day eligibility period, or have been previously declined coverage by Boston Mutual.

Guaranteed Issue Amounts

AGE	EMPLOYEE	SPOUSE
Under Age 60	**$100,000**	**$30,000**
Ages 60-69	**$50,000**	**$20,000**
Ages 70 and Over	**$10,000**	**N/E**

All life insurance coverage for dependent children is guaranteed issue if applied for during the initial 31 day eligibility period.

REDUCTIONS IN BENEFITS

Employee coverage reduces upon the attainment of age **70** and periodically thereafter in accordance with the following schedule:

to 65 % of the original benefit at age 70
to 50 % of the original benefit at age 75
to 35 % of the original benefit at age 80
to 25% of the original benefit at age 85
to 20% of the original benefit at age 90
to 15% of the original benefit at age 95

Spouse insurance terminates upon the attainment of age **70** *. Dependent children coverage terminates upon notice that all dependent children are no longer eligible. All insurance benefits shall terminate upon the employee's retirement.*

see other side

ADDITIONAL FEATURES

Accidental Death & Dismemberment: The Voluntary Life Insurance benefit is doubled if death is the result of a covered accident. Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions.

Portability: If you leave your employer prior to age **60** , the coverage is portable for you, your spouse under age **60** and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or Group Voluntary AD&D.

Conversion: Employees have 31 days from the date of termination to convert the voluntary life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or Voluntary AD&D.

Waiver of Premium: If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Accelerated Death Benefit: This provision enables an employee diagnosed and certified by a Doctor as having a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary. To be eligible, the employee must have purchased at least $10,000 in voluntary life coverage.

Also Included: Education Benefit, Seat Belt Benefit, and Repatriation of Remains Benefit. These benefits pertain to the accidental death & dismemberment only.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: intentionally self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefits administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

TOWN OF BOURNE VOLUNTARY TERM LIFE AND AD&D RATES

Must have Basic Life to sign up for Optional Life

BASIC PLAN = $10,000 COVERAGE AT AN EMPLOYEE COST OF $3.60/MONTH

GUARANTEED ISSUE AMOUNTS

AGE	Under 60	60-69
Employee	$ 100,000	$ 50,000
Spouse	$ 30,000	$ 20,000
Dependent	$ 5,000	

MONTHLY PREMIUM

Age	Monthly Premium Rate per 1,000	10,000	20,000	30,000	40,000	50,000	60,000	70,000	80,000	90,000	**100,000**
<35	$0.11	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	$11.00
35-39	$0.14	$1.40	$2.80	$4.20	$5.60	$7.00	$8.40	$9.80	$11.20	$12.60	$14.00
40-44	$0.21	$2.10	$4.20	$6.30	$8.40	$10.50	$12.60	$14.70	$16.80	$18.90	$21.00
45-49	$0.30	$3.00	$6.00	$9.00	$12.00	$15.00	$18.00	$21.00	$24.00	$27.00	$30.00
50-54	$0.48	$4.80	$9.60	$14.40	$19.20	$24.00	$28.80	$33.60	$38.40	$43.20	$48.00
55-59	$0.72	$7.20	$14.40	$21.60	$28.80	$36.00	$43.20	$50.40	$57.60	$64.80	$72.00
60-64	$0.96	$9.60	$19.20	$28.80	$38.40	$48.00	$57.60	$67.20	$76.80	$86.40	$96.00
65-69	$1.65	$16.50	$33.00	$49.50	$66.00	$82.50	$99.00	$115.50	$132.00	$148.50	$165.00
70-74	$2.90	$29.00	$58.00	$87.00	$116.00	$145.00	$174.00	$203.00	$232.00	$261.00	$290.00

****EMPLOYEE MUST HAVE COVERAGE IN ORDER TO INSURE SPOUSE AND/OR CHILDREN****

- EMPLOYEE LIFE & AD&D = $10,000 TO A MAXIMUM OF $400,000 (NOT TO EXCEED 5 TIMES SALARY)
- SPOUSE LIFE & AD&D = $5,000 TO A MAXIMUM OF $75,000 (NOT TO EXCEED 50% OF EMPLOYEE BENEFIT)
- DEPENDENT (LIFE ONLY) = $500 AGE 14 DAYS TO 1 YEAR; $5,000 AGE 1 YEAR TO AGE 19 OR 25 IF FULL TIME STUDENT ($.95/MONTH)
- DEPENDENT CHILD(REN) - (LIFE ONLY) COVERAGE ALL GUARANTEE ISSUE

Applicants requesting insurance amounts over the guaranteed issue amount will require an Evidence of Insurability Form and Authorization to Release Medical Information. These forms will need to accompany the application .

457b Deferred Compensation (Town Employees)

- Empower
- VOYA

403b Annuities (School Employees)

- VOYA/Plan with Ease

How do I make an informed decision?

These services are completely optional and are not subsidized by the Town. All the above listed services can be paid for through payroll deductions. For additional information, please contact the following sales representatives who work closely with the Town:

Empower 457b Plan (Town)

Sylvia Connor has retired. Please contact the Human Resource office for our new representatives information

https://participant.empower-retirement.com/participant/#/login

VOYA 457b Plan (Town)

Frank Leonard

frank@heritageretire.com

(781) 796-9859

https://www.voya.com/

VOYA/Plan with Ease 403b Plans (School)

See the list on page 48

ENROLLMENT FORM:
Blue Cross Blue Shield
(Medical and Dental)

Please use the following enrollment/change form for all actions related to the Blue Cross Blue Shield Medical and Dental Plans.

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name **Town of Bourne**	Current Medical Group #:	Medical Group #, Transferring To

Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group #, Transferring To

Type of Transaction
❒ ADD ❒ CANCEL
❒ CHANGE Three digit termination code ☐☐☐
❒ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

❒ Open Enrollment ❒ New Hire ❒ COBRA

Change to Family ❒ Add Spouse ❒ Add Dependent

❒ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
❒ Other: _____

2. Yourself (Member 1)

What products? ❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England ❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue ❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group) ❒ Network Blue ❒ PPO ❒ Saver Blue

Membership Type (Medical) ❒ Individual ❒ Family

Membership Type (Dental) ❒ Individual ❒ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code
Home Phone ( )	Cell Phone ( )	Email		
Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	City / State	
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒	

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered)

Plan Type: ❒ Medical ❒ Dental

First Name	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	City / State
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒	

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental	
Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental	
Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental	

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

☐ **HSA: Health Savings Account**	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

ENROLLMENT FORM:
EYEMED VISION

Please use the following enrollment/change form for all actions related to the EyeMed Plan.

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
9905407	TOWN OF BOURNE				

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ADD ☐TERM ☐CHG	Sex ☐ M ☐ F	Member ID	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth

Social Security Number	Home Street Address	City/State/Zip	Home Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee Signature: ______________________________ Date: ____________________

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling. Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

FITNESS REIMBURSEMENT FORM:

Please use the following form for application of reimbursement from Blue Cross Blue Shield for your fitness membership/program.

MASSACHUSETTS

FITNESS REIMBURSEMENT REQUEST

Please print all information clearly. To verify that this reimbursement is offered within your plan, or for more information, you can sign in to MyBlue at **bluecrossma.org** or call the Member Service number on your ID card.
All fitness reimbursement requests must be submitted by March 31 of the following year.

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	**Subscriber's Last Name**	**First Name**	**Middle Initial**
Address – Number and Street	**City**	**State**	**ZIP Code**
Employer's Name			

Claim Information

Member's Last Name	**First Name**	**Middle Initial**	**Date of Birth** ___/___/____

Claim is for (choose one and color in the entire box):

- ☐ Subscriber (policyholder)
- ☐ Spouse (of policyholder)
- ☐ Ex-Spouse
- ☐ Dependent (up to age 26)
- ☐ Other (specify): _____

Name, Address, and Phone Number of Qualified Fitness Expense

Total Dollars requested for Qualified Fitness Expense: $ _____

Calendar year that fees were paid: _____

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)
I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these services. I enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/____

Complete this form and mail it to:
Blue Cross Blue Shield of Massachusetts,
Local Claims Department,
PO Box 986030, Boston, MA 02298

000891752 (2/22)

Please deliver all completed forms to the Bourne Human Resource Office by 4:30 PM on May 15, 2024

Human Resources

24 Perry Avenue

Buzzards Bay, MA 02532

Questions or Concerns?

O: (508) 759-0600 x1306

C: (774) 313-1938

ezarcaro@townofbourne.com

This document is intended to provide general information only. Please visit the provided websites or listed contacts for specific information about the plan you are interested in.

OPEN ENROLLMENT – GUIDE TO EMPLOYEE BENEFITS

Town of Bourne, Massachusetts

May 2024