

Town of Westford	BCBS	Tufts Health Plan	BCBS	Tufts Health Plan	BCBS	Tufts Health Plan
Plan Type:	HMO Blue NE Val+ (Plan 1)	HMO Value (compare to Plan 1)	HMO Blue NE (Plan 2)	HMO Premium (compare to Plan 2)	PPO Blue Care Elect Preferred	Carelink PPO Premium
Plan Year Deductible	N/A	N/A	N/A	N/A	N/A	N/A
OOP Maximum for Inpatient and Ambulatory Surgery	\$1000/\$2000	\$1000/\$2000	N/A	N/A	N/A	N/A
Out of Network Deductible	N/A	N/A	N/A	N/A	\$250 Ind / \$500 Fam	\$250 Ind / \$500 Fam
Out of Network Coinsurance	N/A	N/A	N/A	N/A	20%	20%
Out of Network Maximum Out Of Pocket	N/A	N/A	N/A	N/A	\$1250 Ind / \$2500 Fam	\$1250 Ind / \$2500 Fam
Covered Services	Member Cost	Member Cost	Member Cost	Member Cost	Member Cost	Member Cost
Outpatient Care						
Emergency room visits	\$50 per visit (waived if admitted)	\$50 per visit (waived if admitted)	\$25 per visit (waived if admitted)	\$25 per visit (waived if admitted)	\$50 per visit (waived if admitted)	\$50 per visit (waived if admitted)
Well-child care	\$15 per visit	Covered in full	\$5 per visit	Covered in full	\$15 per visit (age schedule limitations)	Covered in full
Routine physical exams (including one GYN exam per calendar year)	\$15 per visit	Covered in full	\$5 per visit	Covered in full	\$15 per visit (age schedule limitations)	Covered in full
Routine vision exams	\$15 per visit (one every 12 months)	\$15 per visit (one every 12 months)	\$5 per visit (one every 12 months)	\$5 per visit (one every 12 months)	\$15 per visit (one every 12 months)	\$15 per visit (one every 12 months)
Outpatient maternity visits - office visits	\$15 per visit	\$15 per visit (applies to first 10 visits)	\$5 per visit	\$5 per visit (applies to first 10 visits)	\$15 per visit	\$15 per visit (applies to first 10 visits)
Office visits	\$15 per visit	\$15 per visit	\$5 per visit	\$5 per visit	\$15 per visit	\$15 per visit
Chiropractor services (20 visits per year)	\$15 per visit	\$15 per visit	\$5 per visit	\$5 per visit	\$15 per visit	\$15 per visit
Short-term rehabilitation therapy - physical and occupational	\$15 per visit (combined 60 day max)	\$15 per visit (60 visits for PT, 60 visits for OT)	\$5 per visit (combined 60 day max)	\$5 per visit (60 visits for PT, 60 visits for OT)	\$15 per visit (combined 60 day max)	\$15 per visit (60 visits for PT, 60 visits for OT)
Speech, hearing, and language disorder treatment - speech therapy	\$15 per visit	\$15 per visit (no visit limit)	\$5 per visit	\$5 per visit (no visit limit)	\$15 per visit	\$15 per visit (no visit limit)
Allergy injections only	\$5 per visit	\$5 per visit	\$5 per visit	\$5 per visit	\$5 per visit	\$5 per visit
Preventive mammograms and Pap smears	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic X-rays, lab tests, and other tests	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
High Tech Imaging copayment	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Home health care, including hospice services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Durable medical equipment and repairs - such as wheelchairs, crutches, hospital beds	All charges, with a calendar year maximum of \$750	70% coinsurance with no annual maximum	All charges, with a calendar year maximum of \$1500	70% coinsurance with no annual maximum	All charges, with a calendar year maximum of \$750	70% coinsurance with no annual maximum
Day Surgery	\$150 per admission	\$150 per admission	Covered in full	Covered in full	Covered in full	Covered in full
Inpatient Care (including maternity care)						
General or chronic disease hospital care	\$250 per admission	\$250 per admission	Covered in full	Covered in full	Covered in full	Covered in full
Rehabilitation hospital care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Skilled nursing facility care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prescription Drug Benefits						
Name of Mail order vendor	Express Scripts	CareMark	Express Scripts	CareMark	Express Scripts	CareMark
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)						
Calendar year deductible	None	None	None	None	None	None
Tier 1	\$10 for Tier 1	\$10 for Tier 1	\$10 for Tier 1	\$10 for Tier 1	\$10 for Tier 1	\$10 for Tier 1
Tier 2	\$20 for Tier 2	\$20 for Tier 2	\$20 for Tier 2	\$20 for Tier 2	\$20 for Tier 2	\$20 for Tier 2
Tier 3	\$35 for Tier 3	\$35 for Tier 3	\$35 for Tier 3	\$35 for Tier 3	\$35 for Tier 3	\$35 for Tier 3

Through the mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)						
Tier 1	\$10 for Tier 1	\$10 for Tier 1	\$10 for Tier 1	\$10 for Tier 1	\$10 for Tier 1	\$10 for Tier 1
Tier 2	\$20 for Tier 2	\$20 for Tier 2	\$20 for Tier 2	\$20 for Tier 2	\$20 for Tier 2	\$20 for Tier 2
Tier 3	\$35 for Tier 3	\$35 for Tier 3	\$35 for Tier 3	\$35 for Tier 3	\$35 for Tier 3	\$35 for Tier 3
Mental Health and Substance Abuse Treatment						
Biologically based conditions						
Inpatient admissions in a general hospital or mental hospital	\$250 per admission	\$250 per admission	Covered in full	Covered in full	Covered in full	Covered in full
Outpatient visits	\$15 per visit (no visit limitation)	\$15 per visit (no visit limitation)	\$5 per visit (no visit limitation)	\$5 per visit (no visit limitation)	\$15 per visit (no visit limitation)	\$15 per visit (no visit limitation)
Alcoholism treatment (in addition to non-biologically based mental conditions)						
Inpatient admissions in a general hospital	\$250 per admission	\$250 per admission	Covered in full	Covered in full	Covered in full	Covered in full
Outpatient visits	\$15 per visit (no visit limitation)	\$15 per visit (no visit limitation)	\$5 per visit (no visit limitation)	\$5 per visit (no visit limitation)	\$15 per visit (no visit limitation)	\$15 per visit (no visit limitation)
Discount/Reimbursement Programs						
A Fitness Benefit toward membership at a health club	\$150 per year maximum, per individual or family	\$150 per year maximum, per individual or family	\$150 per year maximum, per individual or family	\$150 per year maximum, per individual or family	\$150 per year maximum, per individual or family	\$150 per year maximum, per individual or family
Discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies	Discount varies	Discount varies	Discount varies	Discount varies	Discount varies
Discounts on different types of complementary and alternative medicine services such as acupuncture, massage therapy, nutritional counseling, personal training, Pilates, tai chi, and yoga	Discount varies	Discount varies	Discount varies	Discount varies	Discount varies	Discount varies
CVS ExtraCare Card	N/A	20% discount on non-prescription items	N/A	20% discount on non-prescription items	N/A	20% discount on non-prescription items

**Highlighted items denote differences or enhancements from the current plan of benefits. This is only a summary, please refer to your Subscriber Certificate or Evidence of Coverage document for a full description of coverage.

MMA offerings through BCBS have been illustrated based on the current grandfathered plan of benefits. These plans do not include any proposed changes by MMA to their plan of benefits for the 2011 renewal.