Town of Duxbury, Massachusetts

OFFICE OF THE BOARD OF SELECTMEN AND TOWN MANAGER

VIA Certified US and Electronic Mail (delivery confirmation and return receipt requested)

To: Union Presidents and Members of the Insurance Advisory Committee
From: Richard MacDonald, Town Manager
CC: Secretary of Administration and Finance (MunicipalHealth@state.ma.us)
Dr. Benedict Tantillo, III, Superintendent of Schools
Board of Selectmen
School Committee
Date: February 8, 2012
Re: Implementation Notice

This notice is being provided to you pursuant to 801 CMR 52.03 and includes the Town of Duxbury's estimated savings from implementing changes to its health insurance plans pursuant to M.GL. Chapter 32B, Sections 21 and 22. This notice includes all the information required by 801 CMR 52.03.

The Town is proposing modification of our current Blue Cross Blue Shield health insurance plans to match, as closely as possible, the benefit design of the Group Insurance Commission's most popular plan, the Tuft's Navigator, effective September 1, 2012.

The Town would like to meet with the full Insurance Advisory Committee on February 14, 2012 at 3:00PM in Town Hall's Mural Room.

52.03: The Implementation Notice:
a. Proposed changes to the Town's health insurance benefits:
Current Health Insurance Plans:
1. Appendix A the Town of Duxbury's Proposal, New Plan Design & Mitigation Plan, Municipal Health Reform Law details the Town's:
    a. In-force health insurance plans, related co-pays, and other cost-sharing design features for active employee and retiree plans.

878 Tremont Street, Duxbury, MA 02332 Telephone: 781-934-1100 x149 Fax: 781-934-9011
Town-Manager@town.duxbury.ma.us

The mission of the Town of Duxbury is to deliver excellent services to the community in the most fiscally responsible and innovative manner while endeavoring to broaden our sense of community and preserve the unique character of our town.

    b. Breakdown of enrollment by individual and family plans as of 9/20/11 and the related premium costs.
    c. Includes the Town's 75% contribution for active employee plans and 50% for retiree plans.
2. Description of the Proposed Changes:
    a. The earliest practical date for implementing changes under the law is 9/1/12.
    b. A summary of each proposed plan design including co-pays, deductibles and other cost sharing features are detailed in Appendix A. The Town's estimate of anticipated savings of such changes and the supporting information and analysis, conducted by Cook & Company, is also found in Appendix A, including but not limited to:
        1. The total projected premium costs and enrollment of plans under the existing coverage for the first 12 month period in which the Town seeks to make changes.
        2. The anticipated total projected premium costs of plans, including plans with proposed changes and anticipated enrollment for the same 12 month period.

b. As provided under 801 CMR 52.03 (d) the town is proposing to create a mitigation fund equal to up to 25% of the total year one (1) savings. This mitigation proposal includes:
    1. An estimate of the cost to fund the mitigation proposal is found in Appendix A.

Appendix B contains the distribution list used for this memo.

Please contact me immediately if you have any questions or concerns regarding this implementation notice.

878 Tremont Street, Duxbury, MA 02332 Telephone: 781-934-1100 x149 Fax: 781-934-9011
Town-Manager@town.duxbury.ma.us

Appendix A

Town of Duxbury
Municipal Health Reform Law
Proposal
New Plan Design
&
Mitigation Plan

Duxbury Health Plan Proposal
9/1/12 – 8/31/13

Table of Contents

1. Executive Summary

2. Financial Summary

3. Proposed Mitigation Plans

4. Current Plan Year
   - Plan Year 2012 Budget

5. Projected Plan Year 2013
   - Budget

6. Projected GIC Budget
   - Fiscal Year 2013
     a. At current contributions
     b. At 70%/30% contributions

7. Proposed New Plans
   - Benefit Summaries
   - Budget

EXECUTIVE SUMMARY

Town Of Duxbury
Municipal Health Reform Law
Executive Summary

The recently passed Municipal Health Reform Law outlines the procedure for Massachusetts municipalities to either modify their plans to resemble the Group Insurance Commission's (GIC) most popular plan design or to join the GIC plans directly. The following is the Town of Duxbury's proposal for modifying our plans to match as closely as possible the benefit design of the GIC's most popular plan, the Tuft's Navigator.

You will note that our proposal intends to remain with our current carriers, change the benefit design, and as outlined in the new law, share a percentage of the total first year savings with our employees over and above the savings realized by reduced rates. Please also note that, due to contract language, the plan year calculations are from September 1, 2012 through August 31, 2013. Duxbury will, however, remain on a fiscal year anniversary.

In compliance with the new law, we will meet with the Public Employee Committee as often as necessary during the next thirty days to attempt to reach an agreement among all parties. Absent an agreement within 30 days, this proposal will be forwarded to a three person panel who will review it for compliance and, if they agree with the proposal, will instruct the Town to either implement these changes, return to the table to adjust any inconsistencies or to join the GIC plans.

We believe this proposal would reduce the total plan year cost by $1,032,352. The employee share of the rates would be reduced by $303,339 and an additional $258,088 would be set aside by the Town to mitigate the cost of the design changes for employees. In total the employees would receive 54% of the combined savings between rate reduction and the mitigation plan in the first year.

Respectfully Submitted,
The Town of Duxbury

FINANCIAL SUMMARY

Duxbury Summary

PLAN YEAR 9/1/12-8/31/13

		Town Cost	Employee Cost	Total
Projected GIC PLAN 2013				
A. MHP to Ind & Balance to HPHC PPO		6,769,520	3,134,592	9,904,112
	Savings	623,308	314,592	937,900
B. MHP to IND & half to HPHC & Tufts		6,490,031	3,019,309	9,509,340
	Savings	902,797	429,875	1,332,672
C. Same but 2% to Limited HMOs		6,374,441	2,970,606	9,345,047
	Savings	1,018,387	478,578	1,496,965

	Town Cost	Employee Cost	Total
Projected Modified Plan Savings			
Projected Plan Year 2013 In Force Plans	7,392,828	3,449,184	10,842,012
Proposed Plan 2013 New Plans	6,663,815	3,145,845	9,809,660
Projected Savings	729,013	303,339	1,032,352
Mitigation Fund	-258,088	258,088	
NET SAVINGS	470,925	561,427	1,032,352

PROPOSED MITIGATION PLANS

TOWN OF DUXBURY
MITIGATION PROPOSAL

The Town of Duxbury proposes to take twenty-five percent (25%) of the estimated first year savings achieved by modifying the health insurance benefits and create a mitigation fund. While the statute requires that the Town share an amount **up to** 25% of the estimated savings, the Town is proposing to share the **full** 25% of the estimated savings.

The Town proposes to administer the mitigation fund in the following manner: based on projected rates, the $258,088 mitigation amount equates to a Town issued check in the amount of $456 for family plan subscribers and $228 for individual plan subscribers. This will only pertain to those employees/retirees who are enrolled in the Town's plans as of August 31, 2012.

In total the employees would receive slightly more than 54% of the combined savings between rate reduction and the mitigation plan in the first year.

TOWN OF DUXBURY
PROPOSED MITIGATION PLAN*

			Town Total Cost
TOTAL AVAILABLE	**$258,088**		
Town Issued Check	$228 per 490 individuals	$111,720	
	$490 per 456 family	$146,376	$258,096

* All mitigation monies allocated to those participants whose plan designs have changed

CURRENT
PLAN
YEAR

DUXBURY - FISCAL YEAR 2012

For Period 7/1/11 Through 6/30/12

(as of 9/20/11)

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
MASTER HEALTH PLUS	10	I	12	1121.30	840.98	100,917	280.33	33,639	134,556	75.00
	12	F	12	2820.52	2115.39	304,616	705.13	101,539	406,155	75.00
	0	I	12	1121.30	0.00	-	1121.30	-	-	0.00
COBRA	0	F	12	2820.52	0.00	-	2820.52	-	-	0.00
10%		**MASTER HEALTH PLUS TOTALS:**				**405,533**		**135,178**	**540,711**	
MASTER HEALTH PLUS	6	I	12	1121.30	560.65	40,367	560.65	40,367	80,734	50.00
(RETIREES)	2	F	12	2820.52	1410.26	33,846	1410.26	33,846	67,692	50.00
10%		**MASTER HEALTH PLUS TOTALS:**				**74,213**		**74,213**	**148,426**	
BLUE CARE ELECT	51	I	12	662.49	496.87	304,083	165.62	101,361	405,444	75.00
	113	F	12	1657.14	1242.86	1,685,311	414.29	561,770	2,247,082	75.00
COBRA	0	I	12	662.49	0.00	-	662.49	-	-	0.00
	0	F	12	1657.14	0.00	-	1657.14	-	-	0.00
0%		**BLUECARE ELECT TOTALS:**				**1,989,394**		**663,131**	**2,652,526**	
BLUE CARE ELECT	45	I	12	662.49	331.25	178,872	331.25	178,872	357,745	50.00
(RETIREES)	25	F	12	1657.14	828.57	248,571	828.57	248,571	497,142	50.00
0%		**BLUECARE ELECT TOTALS:**				**427,443**		**427,443**	**854,887**	
HMO BLUE	86	I	12	598.96	449.22	463,595	149.74	154,532	618,127	75.00
	176	F	12	1497.38	1123.04	2,371,850	374.35	790,617	3,162,467	75.00
COBRA	2	I	12	598.96	0.00	-	598.96	14,375	14,375	0.00
	1	F	12	1497.38	0.00	-	1497.38	17,969	17,969	0.00
0%		**HMO BLUE TOTALS:**				**2,835,445**		**977,492**	**3,812,937**	
HMO BLUE	18	I	12	598.96	299.48	64,688	299.48	64,688	129,375	50.00
(RETIREES)	13	F	12	1497.38	748.69	116,796	748.69	116,796	233,591	50.00
0%		**HMO BLUE TOTALS:**				**181,483**		**181,483**	**362,967**	
MEDEX	276	I	12	396.00	198.00	655,776	198.00	655,776	1,311,552	50.00
0%		**MEDEX TOTALS:**				**655,776**		**655,776**	**1,311,552**	
Managed Blue for Seniors	0	I	12	318.16	159.08	-	159.08	-	-	50.00
		MBS TOTALS:				-		-	-	
					Budget Totals:	**6,569,288**		**3,114,717**	**9,684,005**	
						67.84%		**32.16%**	**100.00%**	
		Section 18 Penalty				41,000				
					TOTAL	6,610,288				

2/2/2012

PROJECTED

PLAN YEAR

9/1/12-8/31/13

NO CHANGES

DUXBURY - PLAN YEAR 2013

For Period 9/1/12 Through 8/31/13

As of 1/30/12 (FOR SAVINGS CALCULATIONS)

Plan Name		Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
MASTER HEALTH PLUS		10	I	12	1345.56	1009.17	121,100	336.39	40,367	161,467	75.00
	20%	12	F	12	3384.62	2538.47	365,539	846.16	121,846	487,385	75.00
			MASTER HEALTH PLUS TOTALS:				**486,639**		**162,213**	**648,852**	
MASTER HEALTH PLUS		6	I	12	1345.56	672.78	48,440	672.78	48,440	96,880	50.00
(RETIREES)	20%	2	F	12	3384.62	1692.31	40,615	1692.31	40,615	81,231	50.00
			MHP RETIREE TOTALS:				**89,056**		**89,056**	**178,111**	
BLUE CARE ELECT		51	I	12	781.74	586.31	358,819	195.44	119,606	478,425	75.00
	18%	113	F	12	1955.43	1466.57	1,988,672	488.86	662,891	2,651,563	75.00
			BLUECARE ELECT TOTALS:				**2,347,491**		**782,497**	**3,129,988**	
BLUE CARE ELECT		45	I	12	781.74	390.87	211,070	390.87	211,070	422,140	50.00
(RETIREES)	18	25	F	12	1955.43	977.72	293,315	977.72	293,315	586,629	50.00
			BLUECARE ELECT TOTALS:				**504,384**		**504,384**	**1,008,769**	
HMO BLUE		86	I	12	658.86	494.15	509,958	164.72	169,986	679,944	75.00
	'10%	175	F	12	1647.68	1235.76	2,595,096	411.92	865,032	3,460,128	75.00
COBRA		2	I	12	658.86	0.00	-	658.86	15,813	15,813	0.00
			HMO BLUE TOTALS:				**3,105,054**		**1,050,831**	**4,155,884**	
HMO BLUE		18	I	12	658.86	329.43	71,157	329.43	71,157	142,314	50.00
(RETIREES)	10%	13	F	12	1647.68	823.84	128,519	823.84	128,519	257,038	50.00
			HMO BLUE TOTALS:				**199,676**		**199,676**	**399,352**	
MEDEX		278	I	12	396.00	198.00	660,528	198.00	660,528	1,321,056	50.00
	'0%		**MEDEX TOTALS:**				**660,528**		**660,528**	**1,321,056**	
Managed Blue for Seniors		0	I	12	318.16	159.08	-	159.08	-	-	50.00
			MBS TOTALS:				**-**		**-**	**-**	
					Budget Totals:		7,392,828		3,449,184	10,842,012	
							68.19%		31.81%	100.00%	
			Section 18 Penalty				41,000				
						TOTAL	7,433,828				

2/2/2012

PROJECTED
GIC
BUDGETS

COOK

DUXBURY - FISCAL YEAR 2013

A

For Period 7/1/12Through 6/30/13

GIC (all BCE & HMO to HPHC PPO as of 11/30/11)

Plan Name		Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
UNICARE INDEMNITY		10	I	12	910.21	682.66	81,919	227.55	27,306	109,225	75.00
with CIC		12	F	12	2125.01	1593.76	229,501	531.25	76,500	306,001	75.00
7/1/12-6/30/13	**5%**		**UNICARE INDEMNITY TOTALS:**				**311,420**		**103,807**	**415,227**	
UNICARE INDEMNITY		6	I	12	910.21	455.11	32,768	455.11	32,768	65,535	50.00
with CIC Retiree		2	F	12	2125.01	1062.51	25,500	1062.51	25,500	51,000	50.00
7/1/12-6/30/13	**5%**		**UNICARE INDEMNITY TOTALS:**				**58,268**		**58,268**	**116,535**	
HPHC PPO		137	I	12	685.50	514.13	845,222	171.38	281,741	1,126,962	75.00
7/1/12-6/30/13	**5%**	289	F	12	1672.64	1254.48	4,350,537	418.16	1,450,179	5,800,716	75.00
INDEPENDENCE			**HPHC INDEPENDENCE TOTALS:**				**5,195,758**		**1,731,919**	**6,927,678**	
HPHC PPO Retiree		63	I	12	685.50	342.75	259,119	342.75	259,119	518,238	50.00
7/1/12-6/30/13	**5%**	38	F	12	1672.64	836.32	381,362	836.32	381,362	762,724	50.00
INDEPENDENCE			**HPHC INDEPENDENCE TOTALS:**				**640,481**		**640,481**	**1,280,962**	
HPHC PPO COBRA		2	I	12	685.50	0.00	-	685.50	16,452	16,452	0.00
7/1/12-6/30/13	**5%**	1	F	12	1672.64	0.00	-	1672.64	20,072	20,072	0.00
INDEPENDENCE			**HPHC INDEPENDENCE TOTALS:**				**-**		**36,524**	**36,524**	
UNICARE MEDICARE EXTENSION with CIC		276	I	12	375.52	187.76	621,861	187.76	621,861	1,243,722	50.00
7/1/12-6/30/13	**5%**		**TUFTS MCP TOTALS:**				**621,861**		**621,861**	**1,243,722**	
						Budget Totals:	**6,769,520**		**3,134,592**	**9,904,112**	
							68.35%		**31.65%**	**100.00%**	

2/2/2012

DUXBURY - FISCAL YEAR 2013

B

For Period7/1/12 Through6/30/13

GIC (all BCE & HMO split HPHC & Tufs PPO as of 11/30/11)

Plan Name		Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
UNICARE INDEMNITY		10	I	12	910.21	682.66	81,919	227.55	27,306	109,225	75.00
with CIC		12	F	12	2125.01	1593.76	229,501	531.25	76,500	306,001	75.00
7/1/12-6/30/13	**5%**		**UNICARE INDEMNITY TOTALS:**				**311,420**		**103,807**	**415,227**	
UNICARE INDEMNITY		6	I	12	910.21	455.11	32,768	455.11	32,768	65,535	50.00
with CIC Retirees		2	F	12	2125.01	1062.51	25,500	1062.51	25,500	51,000	50.00
7/1/12-6/30/13	**5%**		**UNICARE INDEMNITY TOTALS:**				**58,268**		**58,268**	**116,535**	
HPHC PPO		69	I	12	685.50	514.13	425,696	171.38	141,899	567,594	75.00
7/1/12-6/30/13	**5%**	145	F	12	1672.64	1254.48	2,182,795	418.16	727,598	2,910,394	75.00
INDEPENDENCE			**HPHC INDEPENDENCE TOTALS:**				**2,608,491**		**869,497**	**3,477,988**	
HPHC PPO Retiree		32	I	12	685.50	342.75	131,616	342.75	131,616	263,232	50.00
7/1/12-6/30/13	**5%**	19	F	12	1672.64	836.32	190,681	836.32	190,681	381,362	50.00
INDEPENDENCE			**HPHC INDEPENDENCE TOTALS:**				**322,297**		**322,297**	**644,594**	
HPHC PPO COBRA		2	I	12	652.86	0.00	-	652.86	15,669	15,669	0.00
7/1/12-6/30/13	**5%**	1	F	12	1592.99	0.00	-	1592.99	19,116	19,116	0.00
INDEPENDENCE			**HPHC INDEPENDENCE TOTALS:**				-		**34,785**	**34,785**	
TUFTS PPO		68	I	12	619.86	464.90	379,354	154.97	126,451	505,806	75.00
7/1/12-6/30/13	**5%**	144	F	12	1511.57	1133.68	1,958,995	377.89	652,998	2,611,993	75.00
NAVIGATOR			**TUFTS NAVIGATOR TOTALS:**				**2,338,349**		**779,450**	**3,117,799**	
TUFTS PPO Retirees		31	I	12	619.86	309.93	115,294	309.93	115,294	230,588	50.00
7/1/12-6/30/13	**5%**	19	F	12	1511.57	755.79	172,319	755.79	172,319	344,638	50.00
NAVIGATOR			**TUFTS NAVIGATOR TOTALS:**				**287,613**		**287,613**	**575,226**	
UNICARE MEDICARE EXTENSION with CIC		276	I	12	375.52	187.76	621,861	187.76	621,861	1,243,722	50.00
7/1/12-6/30/13	**5%**		**TUFTS MCP TOTALS:**				**621,861**		**621,861**	**1,243,722**	
					Budget Totals:		**6,490,031**		**3,019,309**	**9,509,340**	
							68.25%		**31.75%**	**100.00%**	

2/2/2012

DUXBURY - FISCAL YEAR 2013

C

For Period 7/1/12 Through 6/30/13

GIC @ 5%

HP to Ind (98% BCE & HMO split HPHC & Tufs PPO, 2% Limited as of 10/30/11)

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
UNICARE INDEMNITY	10	I	12	910.21	682.66	81,919	227.55	27,306	109,225	75.00
with CIC	12	F	12	2125.01	1593.76	229,501	531.25	76,500	306,001	75.00
		UNICARE INDEMNITY TOTALS:				**311,420**		**103,807**	**415,227**	
UNICARE INDEMNITY	6	I	12	910.21	455.11	32,768	455.11	32,768	65,535	50.00
with CIC Retired	2	F	12	2125.01	1062.51	25,500	1062.51	25,500	51,000	50.00
		UNICARE INDEMNITY TOTALS:				**58,268**		**58,268**	**116,535**	
HPHC PPO	68	I	12	685.50	514.13	419,526	171.38	139,842	559,368	75.00
INDEPENDENCE	142	F	12	1672.64	1254.48	2,137,634	418.16	712,545	2,850,179	75.00
		HPHC INDEPENDENCE TOTALS:				**2,557,160**		**852,387**	**3,409,547**	
HPHC PPO Retiree	31	I	12	685.50	342.75	127,503	342.75	127,503	255,006	50.00
INDEPENDENCE	18	F	12	1672.64	836.32	180,645	836.32	180,645	361,290	50.00
		HPHC INDEPENDENCE TOTALS:				**308,148**		**308,148**	**616,296**	
HPHC PPO COBRA	2	I	12	685.50	0.00	-	685.50	16,452	16,452	0.00
INDEPENDENCE	1	F	12	1672.64	0.00	-	1672.64	20,072	20,072	0.00
		HPHC INDEPENDENCE TOTALS:				**-**		**36,524**	**36,524**	
HPHC **Primary Choice**	1	I	12	548.41	411.31	4,936	137.10	1,645	6,581	75.00
HMO	3	F	12	1338.11	1003.58	36,129	334.53	12,043	48,172	75.00
		HPHC Primary Choice TOTALS:				**41,065**		**13,688**	**54,753**	
HPHC **Primary Choice**	1	I	12	548.41	274.21	3,290	274.21	3,290	6,581	50.00
HMO Retired	1	F	12	1338.11	669.06	8,029	669.06	8,029	16,057	50.00
		HPHC Primary Choice TOTALS:				**11,319**		**11,319**	**22,638**	
TUFTS PPO	67	I	12	619.86	464.90	373,776	154.97	124,592	498,367	75.00
NAVIGATOR	141	F	12	1511.57	1133.68	1,918,182	377.89	639,394	2,557,576	75.00
		TUFTS NAVIGATOR TOTALS:				**2,291,958**		**763,986**	**3,055,944**	
TUFTS PPO Retirees	30	I	12	619.86	309.93	111,575	309.93	111,575	223,150	50.00
NAVIGATOR	19	F	12	1511.57	755.79	172,319	755.79	172,319	344,638	50.00
		TUFTS NAVIGATOR TOTALS:				**283,894**		**283,894**	**567,788**	
Tufts Health Plan **Spirit**	1	I	12	495.89	371.92	4,463	123.97	1,488	5,951	75.00
HMO	3	F	12	1209.25	906.94	32,650	302.31	10,883	43,533	75.00
		TUFTS SPIRIT TOTALS:				**37,113**		**12,371**	**49,484**	
Tufts Health Plan **Spirit**	1	I	12	495.89	247.95	2,975	247.95	2,975	5,951	50.00
HMO Rerired	0	F	12	1209.25	604.63	-	604.63	-	-	50.00
		TUFTS SPIRIT TOTALS:				**2,975**		**2,975**	**5,951**	
UNICARE MEDICARE EXTENSION with CIC	276	I	12	375.52	187.76	621,861	187.76	621,861	1,243,722	50.00
		TUFTS MCP TOTALS:				**621,861**		**621,861**	**1,243,722**	
				Budget Totals:		**6,374,441**		**2,970,606**	**9,345,047**	
						68.21%		**31.79%**	**100.00%**	

2/2/2012

PROPOSED
NEW
PLANS

GIC TUFTS NAVIGATOR VERSUS TOWN OF DUXBURY HEALTH PLANS

		GIC		IN FORCE PLANS			
		TUFTS NAVIGATOR		HMO HMO BLUE	Blue Care Elect Preferred		Master Health Plus
		Calendar Year **In Network**	Calendar Year **Out of Network**		Plan Year **In Network**	Plan Year **Out of Network**	
Calendar Year Deductible	Individual Family	$250 $750	$400 $800	NA	NA	$250 $500	NA
Primary Care Office Visit		$20	20% Co pay*	$10	$10	20% Co pay*	$10
Preventive Services		Covered in Full	20% Co Pay*	$10	$10	20% Co pay*	$10
Specialist Office Visit	Tier 1 Tier 2 Tier 3	$25 $35 $45	$35 Plus Balance	$10	$10	20% Co pay*	$10
Emergency Room		$100*	$100*	$50	$50	$50	$50
Hospital Admission	Tier 1 Tier 2 Tier 3	$300* $700*	20% Co pay* Plus any Balance	Covered in Full	Covered in Full	20% Co pay*	Covered in Full
Ambulatory Outpatient Surgery		$150*	20% Co pay* Plus any Balance	Covered in Full	Covered in Full	20% Co pay*	Covered in Full
High Tech Imaging (MRI, CT, PET)	Tier 1 Tier 2 Tier 3	$100* $100* $100*	20% Co pay* Plus any Balance	Covered in Full	Covered in Full	20% Co pay*	Covered in Full
Prescriptions Retail 30-day supply	Tier 1 Tier 2 Tier 3	$10 $25 $50	Not Covered Not Covered Not Covered	$10 $20 $35	$10 $20 $35	Not Covered Not Covered Not Covered	$10 $20 $35
Mail Order 90-day supply	Tier 1 Tier 2 Tier 3	$20 $50 $110	Not Covered Not Covered Not Covered	$10 $20 $35	$10 $20 $35	Not Covered Not Covered Not Covered	$10 $20 $35

* After Deductible

GIC TUFTS NAVIGATOR VERSUS TOWN OF DUXBURY PROPOSED HEALTH PLANS

		GIC		PROPOSED PLANS			
		TUFTS NAVIGATOR		NET BLUE NE 250/750 Deduct	Blue Care Elect HCCS		MHP GIC Type
		Calendar Year	Calendar Year	Plan Year**	Plan Year**	Plan Year***	Plan Year**
		In Network	**Out of Network**		**In Network**	**Out of Network**	
Deductible	Individual Family	$250 $750	$400 $800	$250 $750	$250 $750	$400 $800	$250 $750
Primary Care Office Visit		$20	20% Co pay*	$20	$20	20% Co pay*	$20
Preventive Services		Covered in Full	20% Co Pay*	Covered in Full	Covered in Full	20% Co Pay*	Covered in Full
Specialist Office Visit	Tier 1 Tier 2 Tier 3	$25 $35 $45	$35 Plus Balance	$35	$35	20% Co pay*	$20
Emergency Room		$100*	$100*	$100*	$100*	$100*	$100
Hospital Admission	Tier 1 Tier 2 Tier 3	$300* $700* Max 4 per year	20% Co pay* Plus any Balance	OOP Max $1200P/P $300 $300* $700*	$300* $700*	20% Co pay* 20% Co pay*	OOP Max $1200P/P $300 $300* $700*
Ambulatory Outpatient Surgery		$150* Max 4 per year	20% Co pay* Plus any Balance	OOP Max $600P/P $150 $150* $150*	$150*	20% Co pay*	OOP Max $600P/P $150* $150* $150*
High Tech Imaging (MRI, CT, PET)	Tier 1 Tier 2 Tier 3	$100* $100* $100*	20% Co pay* Plus any Balance	$100* $100* $100*	$100* $100* $100*	20% Co pay* 20% Co pay* 20% Co pay*	$100* $100* $100*
Prescriptions Retail 30-day supply	Tier 1 Tier 2 Tier 3	$10 $25 $50	Not Covered Not Covered Not Covered	$10 $25 $50	$10 $25 $50	Not Covered Not Covered Not Covered	$10 $25 $50
Mail Order 90-day supply	Tier 1 Tier 2 Tier 3	$20 $50 $110	Not Covered Not Covered Not Covered	$20 $50 $110	$20 $50 $110	Not Covered Not Covered Not Covered	$20 $50 $110

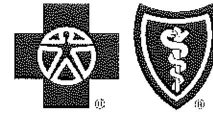
GIC: * After Deductible

Proposed Plans:
* After Deductible
** Plan Year Out Of Pocket Max $2,000/$4,000
***PPO Out of Network OOP Individlal Max $3,000

GIC UNICARE OME VERSUS TOWN OF DUXBURY MEDEX

		UNICARE OME	CURRENT TOWN OF DUXBURY MEDEX	PROPOSED TOWN OF DUXBURY MEDEX
Office Visit		$0 after $35 calendar	Covered in Full	$0 after $35 calendar year deductible
Preventive Services		Covered in Full	Covered in Full	Covered in Full
Emergency Room		$25	Covered in Full	$25
Hospital Admission		$50 per admission (max 1 co-pay per calendar quarter)	Covered in Full	$50 per admission (max 1 co-pay per calendar quarter)
Prescriptions				
Retail 30-day supply	Tier 1	$10	$10	$10
	Tier 2	$25	$20	$20
	Tier 3	$50	$35	$35
Mail Order 90-day supply	Tier 1	$20	$10	$20
	Tier 2	$50	$20	$40
	Tier 3	$110	$35	$70

DRAFT
By: czabil01 2:58 pm, Dec 28, 2011



Network Blue®

Plan-Year Deductible: $250/$750

Summary of Benefits

Town of Duxbury

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2011, as part of the Massachusetts Health Care Reform Law.

An Association of Independent Blue Cross and Blue Shield Plans

Your Care

Your Primary Care Provider.

When you enroll in Network Blue, you must choose a primary care provider (PCP) for you and each member of your family. There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the Provider Directory; or call our Physician Selection Service at **1-800-821-1388**. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist. The specialist will usually be one your PCP knows, probably someone affiliated with your PCP's hospital or medical group. Your provider may also work with Blue Cross Blue Shield concerning the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review is detailed in 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 care in "higher cost share hospital,"

Please note: If your PCP refers you to another hospital it is important to check whether the hospital you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive inpatient services at these hospitals, even if your PCP refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Berkshire Medical Center
- Brigham and Women's Hospital
- Cape Cod Hospital
- Children's Hospital Medical Center
- Dana-Farber Cancer Institute
- Fairview Hospital
- Harrington Memorial Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

Your Deductible.

You must pay a plan-year deductible before coverage is provided for certain services. If you are not sure when your plan year begins, contact your group. Your deductible is **$250** per member each plan year (or **$750** per family. **This deductible does not apply to all services.** See the chart on the opposite and back page for the list of services that are subject to the deductible.

Your Out-of-Pocket Maximum.

When the money you pay for the deductible, copayments that are more than **$100** per visit (if any) and co-insurance equals **$2,000** for a member in a plan year (or **$4,000** per family), benefits for that member (or that family) will be provided in full for those covered services, based on the allowed charge, for the rest of that plan year. The money you pay for prescription drug benefits is not included in calculating the out-of-pocket maximum. You will still have to pay any costs that are not included in calculating the out-of-pocket maximum.

Emergency Care—Wherever You Are.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After your deductible, you pay a **$100** copayment per visit for emergency room services. The copayment is waived if you're admitted to the hospital or for an observation stay.

Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts.

When Outside the Service Area.

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

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan-Year Deductible	$250 per member/$750 per family
Covered Services	**Your Cost**
Outpatient Services Well-child care visits	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	Nothing, no deductible
Routine vision exams (one every 12 months)	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Emergency room visits	$100 per visit, after deductible (copayment waived if admitted or for observation stay)
Mental health and substance abuse treatment	$20 per visit, no deductible
Office visits • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	 $20 per visit, no deductible $35 per visit, no deductible
Chiropractor services (up to 12 visits per calendar year)	$20 per visit, no deductible
Surgery in an office setting • When performed by your PCP or OB/GYN • When performed by other network providers	 $20 per visit, no deductible $35 per visit, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per date of service after deductible
Oxygen and equipment for its administration	Nothing after deductible
Home health care and hospice services	Nothing after deductible
Prosthetic devices	20% co-insurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	20% co-insurance after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible
Inpatient Care (including maternity care) • General care hospital (as many days as medically necessary) • In 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)	Nothing after deductible
Mental health or substance abuse care • General hospital (as many days as medically necessary) • Mental hospital or substance abuse facility (as many days as medically necessary)	 $300 per admission after deductible $300 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing, no deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing, no 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.

Your Medical Benefits (continued)

Covered Services	Your Cost
Prescription Drug Benefits **(These services are not subject to the plan-year deductible)** 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 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

Get the Most from Your Plan

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

A Fitness Benefit toward membership at a health club (see your benefit description for details)	$300 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Blue Care Line[SM] to answer your health care questions 24 hours a day—call **1-888-247-BLUE (2583)**	No additional charge

Questions? Call 1-800-782-3675.

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

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** to sign up.

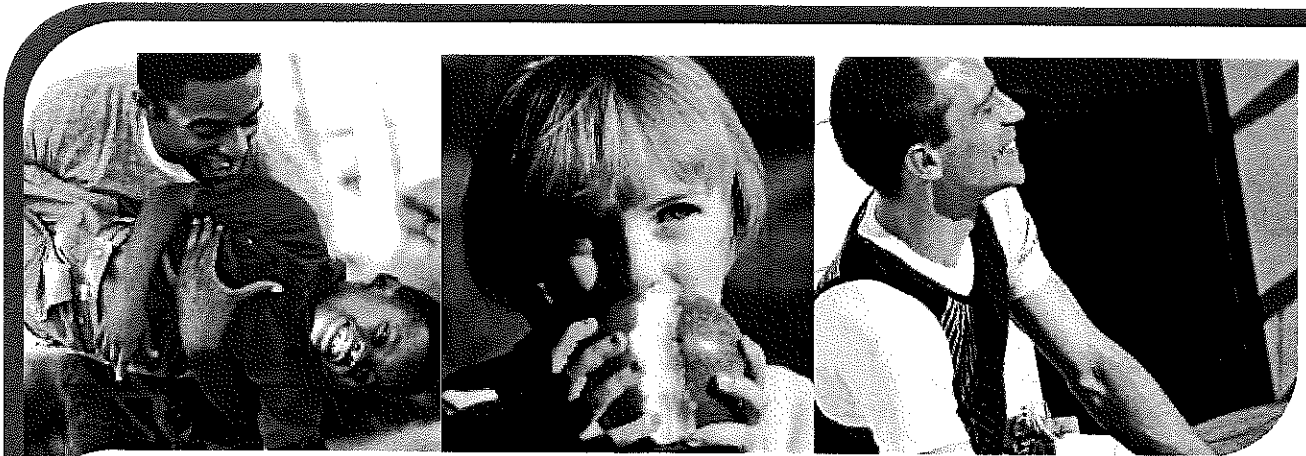
Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not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

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

® Registered Marks of the Blue Cross and Blue Shield Association. SM Service Marks of the Blue Cross and Blue Shield Association.
SM' Service Marks of Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield HMO Blue, Inc.
© 2011 Blue Cross and Blue Shield of Massachusetts, Inc. Printed at Blue Cross and Blue Shield of Massachusetts, Inc.
112088BS (12/11) TBD SB

BlueCross® BlueShield®

DRAFT
By: czabil01 9:09 am, Feb 02, 2012



Blue Care Elect℠ Preferred (PPO)

Summary of Benefits

Town of Duxbury

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 co-insurance) 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 **www.bluecrossma.com/findadoctor** and select the Hospital Choice Cost Sharing Benefit Feature.

✔ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, as part of the Massachusetts Health Care Reform Law.

An Association of Independent Blue Cross and Blue Shield Plans

Your Choice

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

When You Choose Preferred Providers.

Your deductible is calculated on a plan-year basis. Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for some benefits under this plan. The plan year begins on July 1 and ends on June 30.
Your deductible is the first **$250** of covered charges per member each plan year (or **$750** per family). You must also pay a copayment for some services. See the chart on the opposite and back page for services that are subject to the deductible and your cost share amounts.

When the money paid for the deductible, co-insurance and copayments that are more than **$100** per visit (if any) equals **$2,000** for a member in a plan year (or **$4,000** per family), benefits for that member (or that family) will be provided in full for those covered services, based on the allowed charge, for the rest of that plan year. The money you pay for prescription drug benefits is not included in calculating the out-of-pocket maximum. You will still have to pay any costs that are not included in calculating the out-of-pocket maximum.

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

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Berkshire Medical Center
- Brigham and Women's Hospital
- Cape Cod Hospital
- Children's Hospital Medical Center
- Dana-Farber Cancer Institute
- Fairview Hospital
- Harrington Memorial Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com** for Massachusetts providers.
- Visit the BlueCard® Provider Finder website at **http://provider.bcbs.com.**
- Call the BlueCard Program at **1-800-810-BLUE** (2583), 24 hours a day, seven days a week.

When You Choose Non-Preferred Providers.

You must pay a separate plan-year deductible for most out-of-network covered services. The deductible is **$400** for each member (or **$800** per family). After you have met your deductible, you pay **20** percent co-insurance for most out-of-network covered services.

When the money you pay for the deductible, co-insurance and copayments that are more than **$100** per visit (if any) equals **$3,000** for a member in a plan year, benefits for that member will be provided in full for those covered services, based on the allowed charge, for the rest of that plan year. The money you pay for prescription drug benefits is not included in calculating the out-of-pocket maximum. You will still have to pay any costs that are not included in calculating the out-of-pocket maximum.

Payments for out of network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You will 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).

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). After your deductible, you pay a **$100** copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. There is no deductible for these services.

Utilization Review Requirements.

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

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Plan-year deductible	$250 per member $750 per family	$400 per member $800 per family
Plan-year out-of-pocket maximum	$2,000 per member $4,000 per family	$3,000 per member
Covered Services		
Preventive Care Well-child care exams, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life • One visit per calendar year from age 2 through age 18	Nothing, no deductible	20% co-insurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing, no deductible	20% co-insurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% co-insurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% co-insurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% co-insurance after deductible
Family planning services–office visits	Nothing, no deductible	20% co-insurance after deductible
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits • Primary care providers • Most specialists	$20 per visit, no deductible $35 per visit, no deductible	20% co-insurance after deductible 20% co-insurance after deductible
Chiropractors' office visits	$20 per visit, no deductible	20% co-insurance after deductible
Mental health and substance abuse treatment	$20 per visit, no deductible	20% co-insurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$20 per visit, no deductible	20% co-insurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% co-insurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, and PET scans and nuclear cardiac imaging tests	Nothing after deductible	20% co-insurance after deductible
CT scans, MRIs, and PET scans and nuclear cardiac imaging tests	$100 per category per date of service after deductible	20% co-insurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% co-insurance after deductible
Home health care and hospice services	Nothing after deductible	20% co-insurance after deductible
Prosthetic devices	20% co-insurance after deductible	40% co-insurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	20% co-insurance after deductible	40% co-insurance after deductible
Surgery and related anesthesia in an office or health center setting • Primary care providers • Most specialists	$20 per visit, no deductible $35 per visit, no deductible	20% co-insurance after deductible 20% co-insurance after deductible
Surgery and related anesthesia in other than an office setting	$150 per admission after deductible	20% co-insurance 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.

Your Medical Benefits (continued)

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient Care (including maternity care)		
• General or chronic disease hospital care (as many days as medically necessary)	$300 per admission after deductible	20% co-insurance after deductible
• In higher cost share hospitals (as many days as medically necessary)	$700 per admission after deductible	20% co-insurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$300 per admission after deductible	20% co-insurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1 $25 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1 $50 for Tier 2 $110 for Tier 3	Not covered

Get the Most from Your Plan

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

A Fitness Benefit toward membership at a health club (see your benefit description for details)	$300 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Blue Care Line℠ to answer your health care questions 24 hours a day–call **1-888-247-BLUE (2583)**	No additional charge

Questions? Call 1-800-782-3675.

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

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. The benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit descriptions and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.
Please Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

® Registered Marks of the Blue Cross and Blue Shield Association. SM Service Marks of the Blue Cross and Blue Shield Association. SM' Service Marks of Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield HMO Blue, Inc. © 2012 Blue Cross and Blue Shield of Massachusetts, Inc.
Printed at Blue Cross and Blue Shield of Massachusetts, Inc.

112089BS (1/12) TBD CD

BlueCross® BlueShield®

DRAFT
By: ppayac01 3:11 pm, Dec 28, 2011

Master Health Plus®

Summary of Benefits

Town of Duxbury

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, as part of the Massachusetts Health Care Reform Law.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

About the Plan

You Are Free to Choose.

With Master Health Plus, you may use any Blue Cross Blue Shield-participating provider in the United States. In Massachusetts, all general hospitals and most physicians participate with Blue Cross Blue Shield. There are no claim forms for services you receive in Massachusetts by a participating provider. Your plan gives you nationwide access to participating hospitals and medical, surgical, and other health care providers.

To Find a Provider.

To find a participating provider within Massachusetts, call our Physician Selection Service at **1-800-821-1388** or visit our website at **www.bluecrossma.com.** If you're receiving care outside of Massachusetts and you need to locate a doctor or hospital that participates with the local Blue Cross Blue Shield plan, or if you need help finding a specialist, just call **1-800-810-BLUE** (2583).

Your Deductible.

Your deductible is calculated on a plan-year basis. For some services, you must meet the plan-year deductible before benefits are provided. Your plan year is from July 1 through June 30. The deductible is **$250** for each member (or **$750** per family) each plan year.

Out-of-Pocket Maximum for Certain Copayments.

You're protected by an out-of-pocket maximum of **$2,000** in a plan year (or **$4,000 per family**). The deductible, copayments that are more than **$100** per visit, and co-insurance are counted toward the out-of-pocket maximum. Prescription drug copayments are not included in calculating the out-of-pocket maximum. You will have to pay any costs that are not included in the out-of-pocket maximum.

The BlueCard® Program.

The BlueCard Program gives you access to participating providers throughout the United States. There are no claims to submit, no paperwork, and no up-front costs. You need only go to a BlueCard-participating doctor or hospital and show your ID card when you need care. If you choose to see a non-participating provider, you may have to file the claim yourself to be reimbursed for your expenses. (Please note: participating providers are restricted from billing you for the balance of their charges that exceed the negotiated discount amount except as provided otherwise by law.)

You can find participating providers or check a provider's current status in several ways:

- Call **1-800-810-BLUE (2583)**. Please have your ID card ready. If you have not received your ID card, let the representative know that you are looking for participating providers in the area in which you wish to seek care.
- Visit the BlueCard Provider Finder website at **http://provider.bcbs.com.**

Please note: If you are outside the United States and need medical care, call **1-800-810-BLUE (2583).** A medical assistance coordinator, along with a nurse, will make a doctor's appointment for you or arrange for hospitalization if necessary.

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). After the deductible, you pay a **$100** copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. ~~There is no deductible for these services.~~

Utilization Review Requirements.

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

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics	Your Cost
Plan-year deductible	$250 per member $750 per family
Plan-year out-of-pocket maximum (includes deductible, copayments that are more than $100 per visit, and co-insurance)	$2,000 per member $4,000 per family
Covered Services	
Outpatient Care Emergency room services	$100 per visit after deductible (waived if admitted or for observation stay)
Hospital outpatient department services	$25 per visit
Professional provider and health center services for emergency care	$25 per visit
Well-child care exams, including related tests, according to age-based schedule as follows: • Six visits during the first year of life • Three visits during the second year of life • One visit per calendar year from age 2 through age 18	Nothing
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing
Routine hearing exams	Nothing
Routine vision exams (one every 12 months)	Nothing
Family planning services–office visits	Nothing
Physicians', podiatrists', and chiropractors' office visits	$25 per visit
Mental health and substance abuse treatment • Hospital services • Office visits or health center services	 $25 per visit $25 per visit
Short-term rehabilitation therapy–physical and occupational • Hospital services • Professional provider or health center services	 $25 per visit $25 per visit
Speech, hearing, and language disorder treatment–speech therapy • Hospital services • Health center, speech/language pathologists', and audiologists' services	 $25 per visit $25 per visit
Diagnostic X-rays, lab tests, and other tests, excluding MRIs, CT scans, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per date of service after deductible
Home health care and hospice services	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	20% co-insurance after deductible
Oxygen and equipment for its administration	20% co-insurance after deductible
Prosthetic devices	20% co-insurance after deductible
Surgery and related anesthesia • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	 $25 per visit $150 per admission after deductible
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	 $10 for Tier 1 $25 for Tier 2 $50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1 $50 for Tier 2 $110 for Tier 3

Your Medical Benefits (continued)

Covered Services	Your Cost
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	$500 per admission after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$500 per admission after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (as many days as medically necessary)	Nothing after deductible

Get the Most from Your Plan.

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

Questions? Call 1-800-782-3675.

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

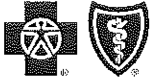
Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids; 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. In Massachusetts, benefits are provided only when a covered service or supply is furnished by a participating provider (except emergencies). **Please note:** Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payment only and does not assume financial risk for claims.

® Registered Marks of the Blue Cross and Blue Shield Association. ®´ Registered Mark of Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield HMO Blue, Inc. SM Service Marks of the Blue Cross and Blue Shield Association. SM´ Service Marks of Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield HMO Blue, Inc. © 2011 Blue Cross and Blue Shield of Massachusetts, Inc.
Printed at Blue Cross and Blue Shield of Massachusetts, Inc.

MASSACHUSETTS

112091BS (12/11) PDF CD



DRAFT
By: ppayac01 2:47 pm, Feb 03, 2012

Medex

Medex® 3 Plan 2012–Summary of Benefits

This Medex plan provides benefits for the:

- Medicare Part A Deductible and Co-insurances
- Medicare Part B Deductible and Co-insurance
- Prescription Drugs
- OBRA Benefits

Town of Duxbury

This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance; however, the Commonwealth of Massachusetts has stated that enrollment in Original Medicare (Medicare Part A and Medicare Part B) satisfies these standards.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Your Medical Benefits

	Medicare Provides	Medex Provides
Inpatient Care		
Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services†	• Coverage for days 1–60 per benefit period after $1,156 inpatient deductible • Coverage for days 61–90 after $289 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $578 daily co-insurance	After a $50 inpatient calendar-quarter copayment: • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits are used up††
Physician or other professional provider services	80% of approved charges after $140 annual Part B deductible	Full coverage of Medicare deductible and co-insurance
Skilled nursing facility—participating with Medicare*	• Full coverage for days 1–20 • Coverage for days 21–100 after daily $144.50 co-insurance	• Full coverage of Medicare daily co-insurance for days 21–100 • $16 daily for days 101–365
Skilled nursing facility—not participating with Medicare*	No benefits	$16 daily for 365 days per benefit period
Outpatient Care		
Office visits	80% of approved charges after $140 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible
Emergency room visits for accident treatment, sudden and serious medical emergency treatment	80% of approved charges after $140 annual Part B deductible	Full coverage after member pays $25 per visit (waived if admitted or for observation stay)
Outpatient surgery, X-rays and lab tests	80% of approved charges after $140 annual Part B deductible	Full coverage of Medicare deductible and co-insurance
Radiation therapy, durable medical equipment, cardiac rehabilitation services, home health care services, and hospice services	80% of approved charges after $140 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible
Blood glucose monitors and materials to test for the presence of blood sugar	80% of approved charges after $140 annual Part B deductible for all diabetics	Full coverage of Medicare deductible and co-insurance
Urine test strips (Claims must be submitted on a Medex Subscriber Claim form.)	No benefits	Covered to the same extent as brand-name prescription drugs
Chiropractor services	80% of approved charges after $140 annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray	• Full coverage of Medicare deductible and co-insurance for Medicare-approved charges only • 20% of the approved charges for services not covered by Medicare
Short-term rehabilitation		
Physical therapy, speech-pathology, and occupational therapy		
Professional provider outpatient services approved by Medicare	80% of approved charges after $140 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible

	Medicare Provides	Medex Provides
Mental Health and Substance Abuse Treatment		
Biologically based mental conditions**		
Inpatient admissions in a general or mental hospital	• Coverage for days 1–60 per benefit period after $1,156 inpatient deductible • Coverage for days 61–90 after $289 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $578 daily co-insurance • Coverage for mental hospital admissions is limited to 190 days per lifetime	After a $50 inpatient calendar-quarter copayment:*** • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime, when Medicare benefits are used up††
Outpatient visits	Full coverage after $140 annual Part B deductible and the Part B co-insurance	• When covered by Medicare, full coverage of Medicare Part B deductible and co-insurance with no visit maximum • When visits are not covered by Medicare, full coverage with no visit maximum
Non-biologically based mental conditions		
Inpatient admissions in a general hospital	• Coverage for days 1–60 per benefit period after $1,156 inpatient deductible • Coverage for days 61–90 after $289 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $578 daily co-insurance	After a $50 inpatient calendar-quarter copayment: • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime, when Medicare benefits are used up††
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to 190 days per lifetime	• Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • When Medicare benefits are used up, full coverage up to 120 days per benefit period (at least 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)††
Outpatient visits	Full coverage after $140 annual Part B deductible and the Part B co-insurance	• When covered by Medicare, full coverage of Medicare Part B deductible and co-insurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year

† Dental services are not covered by Medicare, however, when your medical or dental condition requires an inpatient admission, Medex provides full coverage for hospital and participating dentist charges for surgical removal of unerupted teeth or teeth impacted in bone, and the extraction of seven or more permanent teeth.

†† The additional days are a combination of days in a general or mental hospital.

* A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

** Treatment of rape-related mental or emotional disorders for victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

*** The inpatient calendar-quarter copayment does not apply to admissions in a mental hospital.

	Medicare Benefits	Medex Provides
Prescription Drugs		
At a designated retail pharmacy	Medicare does not provide coverage for prescription drugs used outside of the hospital. See your Medicare handbook for certain covered drugs.	Full coverage after a: • $10 copayment for Tier 1 • $20 copayment for Tier 2 • $35 copayment for Tier 3
Through the designated mail-service pharmacy (up to a 90-day supply for each prescription or refill)	No benefits	Full coverage after a: • $20 copayment for Tier 1 • $40 copayment for Tier 2 • $70 copayment for Tier 3

Preventive Services Approved by Medicare and Medex

- One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)
- One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests)
- One routine colonoscopy every two years for a high-risk member (Full coverage for tests)
- Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare (Full coverage for tests)
- Routine prostate cancer screening for members 50 or older including one (PSA) test and one digital rectal exam, per calendar year (Full coverage for exam if doctor accepts assignment, full coverage for PSA test)
- One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)
- One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)
- One baseline mammogram during the five year period a member is age 35-39 and one routine mammogram per calendar year for members age 40 and older (Full coverage for screening)
- One routine Pap smear test per calendar year (Full coverage for test)

Important Information

- Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.
- The Medicare inpatient deductible and co-insurance amounts are subject to change January 1 of each year. The deductibles and co-insurance amounts listed here are for the year 2012.
- Benefits are available immediately upon your effective date.
- You are encouraged to use an Express Scripts pharmacy outside of Massachusetts. These pharmacies will file claims for you as long as you have your ID card with you.

Questions? Call 1-800-782-3675. (TTY) 1-800-522-1254.

The Member Service staff can assist you Monday through Friday, 8 a.m. to 6 p.m.

Medicare Office Telephone Number in Massachusetts: **1-800-MEDICARE (1-800-633-4227)**

For more information about Blue Cross Blue Shield of Massachusetts, log on to: **www.bluecrossma.com.**

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your plan description and riders define the full terms and conditions. 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. **Please Note:** Blue Cross and Blue Shield of Massachusetts, Inc. is the administrator of the benefits described in this Summary of Benefits. Blue Cross Blue Shield administers claim payments only and does not assume financial risk for claims.

® Registered Marks of the Blue Cross and Blue Shield Association. ®´ Registered Marks of Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. © 2012 Blue Cross and Blue Shield of Massachusetts, Inc. Printed at Blue Cross and Blue Shield of Massachusetts, Inc.
112833BS (1/12) PDF CD

MASSACHUSETTS

DUXBURY - PLAN YEAR 2013

For Period 9/1/12 Through 8/31/13

NEW PLANS As of 11/30/11

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
MASTER HEALTH PLUS	10	I	12	1211.00	908.25	108,990	302.75	36,330	145,320	75.00
-9%	10	F	12	3046.16	2284.62	274,154	761.54	91,385	365,539	75.00
MASTER HEALTH PLUS	0	I	12	1345.56	1009.17	-	336.39	-	-	75.00
POLICE	2	F	12	3384.62	2538.47	60,923	846.16	20,308	81,231	75.00
MASTER HEALTH PLUS	6	I	12	1211.00	605.50	43,596	605.50	43,596	87,192	50.00
(RETIREES)	2	F	12	3046.16	1523.08	36,554	1523.08	36,554	73,108	50.00
-9%		**MASTER HEALTH PLUS TOTALS:**				**524,217**		**228,172**	**752,390**	
BLUE CARE ELECT	49	I	12	672.30	504.23	296,484	168.08	98,828	395,312	75.00
-14%	103	F	12	1681.67	1261.25	1,558,908	420.42	519,636	2,078,544	75.00
BLUE CARE ELECT	2	I	12	781.74	586.31	14,071	195.44	4,690	18,762	75.00
POLICE	10	F	12	1955.43	1466.57	175,989	488.86	58,663	234,652	75.00
BLUE CARE ELECT	45	I	12	672.30	336.15	181,521	336.15	181,521	363,042	50.00
(RETIREES)	25	F	12	1681.67	840.84	252,251	840.84	252,251	504,501	50.00
-14%		**BLUECARE ELECT TOTALS:**				**2,479,224**		**1,115,589**	**3,594,813**	
HMO BLUE	84	I	12	599.56	449.67	453,267	149.89	151,089	604,356	75.00
	168	F	12	1499.39	1124.54	2,267,078	374.85	755,693	3,022,770	75.00
COBRA	2	I	12	599.56	0.00	-	599.56	14,389	14,389	0.00
	1	F	12	1499.39	0.00	-	1499.39	17,993	17,993	0.00
-9%		**HMO BLUE TOTALS:**				**2,720,345**		**939,164**	**3,659,509**	
HMO BLUE	2	I	12	658.86	494.15	11,859	164.72	3,953	15,813	75.00
POLICE	7	F	12	1647.68	1235.76	103,804	411.92	34,601	138,405	75.00
		HMO BLUE TOTALS:				**115,663**		**38,554**	**154,218**	
HMO BLUE	18	I	12	599.56	299.78	64,752	299.78	64,752	129,505	50.00
(RETIREES)	13	F	12	1499.39	749.70	116,952	749.70	116,952	233,905	50.00
-9%		**HMO BLUE TOTALS:**				**181,705**		**181,705**	**363,410**	
MEDEX	276	I	12	388.08	194.04	642,660	194.04	642,660	1,285,321	50.00
-2%		**MEDEX TOTALS:**				**642,660**		**642,660**	**1,285,321**	
Managed Blue for Seniors	0	I	12	318.16	159.08	-	159.08	-	-	50.00
		MBS TOTALS:				-		-	-	
				Budget Totals:		**6,663,815**		**3,145,845**	**9,809,660**	
						67.93%		**32.07%**	**100.00%**	
		Section 18 Penalty				**41,000**				
				TOTAL		**6,704,815**				

2/3/2012

Appendix B

Distribution List
801 CMR 52.03

Prefix	First Name	Last Name	Title	Union/Organization	Location	Street Address	Town/State	Email
Ms.	Debbie	Perez	Union Steward	Duxbury Teachers Association, Instructional Assistants Unit C	Duxbury Public Schools	PO Box 1611	Duxbury, MA 02331-1611	dperez@duxbury.k12.ma.us
Ms.	Nancy	Chadwick	President	Duxbury Teachers Association	Duxbury Public Schools	PO Box 1611	Duxbury, MA 02331-1611	dtaunion@gmail.com
Mr.	Michael	Hammer	Union Steward	School Custodians, AFSCME 93 Local 1700	Duxbury Public Schools	130 St. George Street	Duxbury, MA 02332	mhammer@duxbury.k12.ma.us
Mr.	Brian	DeForest	Member Representative	School Custodians, AFSCME 93 Local 1700	Duxbury Public Schools	11 Beach Road	Plymouth, MA 02360	mrdeforest@verizon.net
Ms.	Karen	Hahn	Union Steward	Duxbury Free Library Employees, SEIU Local 888	Duxbury Free Library	77 Alden Street	Duxbury, MA 02332	khahn@ocln.org
Mr.	Doug	Cunningham	President	Duxbury Permanent Fire Assoc., IAFF Local 2167	Duxbury Fire Department	668 Tremont Street	Duxbury, MA 02332	dougkaitie@verizon.net
Mr.	William	Thomas	Union Steward	Public Safety Dispatchers, MCOP Local 376A	Duxbury Police Department	443 West Street	Duxbury, MA 02332	wthomas@duxburypolice.org
Mr.	Anthony	Vitale	President	Duxbury Police Union, MCOP Local 376B	Duxbury Police Department	443 West Street	Duxbury, MA 02332	anthonyvitale1988@yahoo.com
Lt.	Roger	Banfill	Union Steward	Duxbury Police Commanders Assoc., MCOP Local 376	Duxbury Police Department	443 West Street	Duxbury, MA 02332	rdbanfill@duxburypolice.org
Ms.	Carolyn	Govoni	Union Steward	Town of Duxbury Secretaries & Clerks, SEIU Local 888	Duxbury Town Hall	878 Tremont Street	Duxbury, MA 02332	govoni@town.duxbury.ma.us
Ms.	Trudi	Boc	Union Steward	Town of Duxbury Secretaries & Clerks, SEIU Local 888	Duxbury Town Hall	878 Tremont Street	Duxbury, MA 02333	boc@town.duxbury.ma.us
Mr.	Chip	Locketti	Union Steward	Duxbury DPW Employees, AFSCME 93 Local 1700	Duxbury Town Hall	878 Tremont Street	Duxbury, MA 02332	clocketti@yahoo.com
Mr.	John	Bowser	Retiree	Retiree Representative		480 Elm Street	Duxbury, MA 02333	bowjeb@verizon.net
Mr.	Richard	MacDonald	Town Manager	Town of Duxbury	Duxbury Old Town Hall	878 Tremont Street	Duxbury, MA 02333	macdonald@town.duxbury.ma.us
			Board of Selectman	Town of Duxbury	Duxbury Old Town Hall	878 Tremont Street	Duxbury, MA 02332	mello@town.duxbury.ma.us
Dr.	Benedict	Tantillo	Superintendent of Schools	Duxbury Public Schools	Duxbury Public Schools	130 St. George Street	Duxbury, MA 02332	btantillo@duxbury.k12.ma.us
			School Committee	Duxbury Public Schools	Central Business Office	130 St. George Street	Duxbury, MA 02332	School_Committee@duxbury.k12.ma
			Secretary of Administration and Finance			Via email		municipalhealth@state.ma.us