OPEN ENROLLMENT

Guide to Employee Benefits

Fiscal Year 2025

May 1, 2024 through May 31, 2024

(for coverage beginning July 1, 2024)

All Changes Must Be Submitted To Treasurer's Office By May 30, 2024

Overview & Range of Benefits Offered

Welcome to Georgetown's **Open Enrollment Period**! During the month of May, all full-time and 20+ hour part-time employees are invited to sign up for, change, or cancel any of the benefits currently offered through the Town **effective July 1, 2024**. These benefits include health insurance, dental insurance, and vision insurance. Other benefits included in this guide are life insurance programs, assurance (AFLAC) plans, and retirement savings options – all of which you can sign up for, change, or cancel at any time during the year.

HEALTH INSURANCE: Medical, Dental, and Vision Coverage

The Town of Georgetown is currently part of the Massachusetts Interlocal Insurance Association (MIIA), which is comprised of various municipal units of the Commonwealth of Massachusetts. Pooling together allows the members of MIIA to utilize its size to their advantage, and reduce cost margins/administrative expenses to save the Town and its employees money on health insurance costs.

The Town subsidizes the cost of medical insurance, with the employee contributing anywhere from 25% to 40% of the total price depending on the plan that they choose and municipal unit that they work for. The Town subsidizes 50% of the cost of dental insurance. Vision insurance is not subsidized.

For fiscal year 2025: The Blue New England HMO and Blue Care PPO insurance plan costs are increasing by 6.00%. The Select Network $250 HMO plan cost is increasing by 2.58%. Dental and Vision insurance plan costs have not changed.

LIFE INSURANCE COVERAGE

The Town of Georgetown currently partners with Boston Mutual Life Insurance to offer its employees a basic $5,000.00 policy for a very small price. The Town subsidizes 50% of the cost of this plan which can remain active as long as you are employed, and also can be carried into retirement (at a lower coverage amount).

PEACE OF MIND & FUTURE PLANNING: AFLAC & Retirement Plans

The Town also works with AFLAC to provide options for short term disability, life, accident, and other policies that are not subsidized by the Town. Employees can work with our local AFLAC agent to establish a plan and authorize a payroll deduction for the monthly expense.

While all full-time employees are covered by a pension plan, additional retirement savings options are offered (pre-tax) to assist with planning for the future. The Massachusetts SMART Plan is a deferred compensation 457 plan available to state and municipal employees, and allows employees to utilize payroll deductions to save for retirement. Contributions can be made utilizing a particular dollar amount each pay period or a percentage of total pay. Other supplemental retirement plans are available for certain employees.

TOWN OF GEORGETOWN, MASSACHUSETTS

FISCAL YEAR 2025 - INSURANCE RATES

INSURED: July 1, 2024 - June 30, 2025 **PAYMENTS DUE: June 2024 - May 2025**

		MONTHLY TOTAL COST	MONTHLY TOWN SHARE	MONTHLY EMPLOYEE SHARE	**TOWN/SCHOOL 24 PAYMENTS**	**SCHOOL ONLY 21 PAYMENTS**
PPO Blue Care	Family	$ 3,500.04	$ 2,100.02	$ 1,400.02	**$ 700.01**	**$ 800.01**
Town/School Employees	Single	$ 1,413.50	$ 848.10	$ 565.40	**$ 282.70**	**$ 323.09**
HMO Blue New England	Family	$ 2,923.35	$ 1,911.87	$ 1,011.48	**$ 505.74**	**$ 577.99**
Town/School Employees	Single	$ 1,180.54	$ 772.08	$ 408.46	**$ 204.23**	**$ 233.41**
HMO Select Network 250	Family	$ 2,631.02	$ 1,720.68	$ 910.34	**$ 455.17**	**$ 520.19**
Town/School Employees	Single	$ 1,062.49	$ 694.87	$ 367.62	**$ 183.81**	**$ 210.07**
MEDEX 2 (Retirees Only)	Single	$ 188.16	$ 112.90	$ 75.26	**Retirees Only - Renews 01/01**	
BLUE RX (Retirees Only)	Single	$ 180.45	$ 108.27	$ 72.18		
TOTAL (NA for Active Employees)		$ 368.61	$ 221.17	$ 147.44		
Dental Blue Freedom	Family	$ 105.80	$ 52.90	$ 52.90	**$ 26.45**	**$ 30.23**
	Single	$ 43.72	$ 21.86	$ 21.86	**$ 10.93**	**$ 12.49**
Blue 20/20 Vision	Family	$ 16.03	$ -	**$ 16.03**	**Deductions Made Once Per Month**	
	Single	$ 5.83	$ -	**$ 5.83**		
	Single+	$ 10.21	$ -	**$ 10.21**		
	Couple	$ 9.91	$ -	**$ 9.91**		
Boston Mutual Life Insurance					**Deductions Made Once Per Month**	
$5,000	Active	$ 4.50	$ 2.25	**$ 2.25**		
$2,000	Retired	$ 1.80	$ 0.90	**$ 0.90**		

All medical insurance plans (HMO/PPO) have increased in price by +6.00% except the Select Network 250 Plan which has increased by +2.58%. The dental and vision insurance plan rates have not changed. School employees on a 21-week pay schedule have deductions taken out at a different rate and operate on a different coverage schedule than those employees paid throughout the full calendar year. Please feel free to contact the Treasurer's Office at any time with any questions at (978) 352-5723.

Health Insurance

Blue Cross Blue Shield of Massachusetts

HMO Blue New England (*most popular*)

HMO Select Network 250 (*lowest monthly premium cost*)

PPO Blue (*highest monthly premium cost*)

How do I make an informed decision?

The following pages will provide coverage information for the three health insurance plans offered through the Town. While these documents provide a lot of important information about the plans, they should not be considered completely comprehensive. The carrier documents, provided through Blue Cross Blue Shield, are the only documents that coverage is based on. Please contact Blue Cross Blue Shield of Massachusetts if you have any questions at (800) 782-3675 or visit them online at bluecrossma.org

The 2025 eKit, which dives into greater detail on all of the insurance coverages, can be found using the following link or scanning the QR Code at the bottom of this page:

https://planinfo.bluecrossma.com/ekit/2024-miiatownofgeorgetown-en_US.pdf

BlueCross® BlueShield®

MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND OPTIONS V.5

MIIA Town of Georgetown

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 includes a tiered provider network called HMO Blue New England Options v.5. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **bluecrossma.com/findadoctor** and search for HMO Blue New England Options v.5.

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 CARE

Within the HMO Blue New England Options v.5 network, hospitals and groups of primary care providers (PCPs) are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier providers each time you get hospital or PCP care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.

- **Standard Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and are moderate cost relative to our benchmark. This benefit tier includes hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.

- **Basic Benefits Tier**—Includes Massachusetts hospitals that are high cost relative to our benchmark. Also includes primary care providers in Massachusetts who do not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pocket costs when you choose providers in the Basic Benefits Tier.

Note: Primary care providers were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Providers without sufficient data for either cost or quality are placed in the Standard Benefits Tier. Providers that do not meet benchmarks for one or both of the domains and hospitals that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your primary care provider and the facility where your provider has admitting privileges before you choose a PCP or receive care. For example, if you require hospital care and your Enhanced Benefits Tier PCP refers you to an Enhanced Benefits Tier hospital, you would pay the lowest cost sharing for both your PCP and hospital services. Or, if your Enhanced Benefits Tier PCP refers you to a Basic Benefits Tier hospital for care, you will pay the lowest copayments for PCP services, but the highest copayments for hospital services, except in an emergency.

Copayments Outside of Massachusetts and New Hampshire
For network providers outside of Massachusetts and New Hampshire, a network provider who is listed as a general practitioner, internist, family practitioner, pediatrician, obstetrician/gynecologist, nurse practitioner, rural health center, or general hospital is considered an Enhanced Benefits Tier provider. In New Hampshire, a Tier 1 provider equates to an Enhanced Tier Benefits provider and a Tier 2 provider equates to a Standard Tier Benefits provider. Other providers in our New England network carry the higher, specialist copayment.

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 You Can Feel Better About
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 Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for copayments and coinsurance for covered services. If you are not sure when your plan year begins, please contact Blue Cross Blue Shield of Massachusetts. Your out-of-pocket maximum for medical benefits is **$2,500** per member (or **$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

Emergency 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 are admitted to the hospital or for an observation stay. See the chart for your cost share. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital. Any follow-up care must be arranged by your PCP.

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.

Value Care Offering Coverage
Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

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 for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
Preventive Care			
Well-child care exams	Nothing	Nothing	Nothing
Preventive dental care for children under age 12 (one visit each six months)	Nothing	Nothing	Nothing
Routine adult physical exams, including related tests	Nothing	Nothing	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	Nothing	Nothing
Routine hearing exams, including routine tests	Nothing	Nothing	Nothing
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum	All charges beyond the maximum	All charges beyond the maximum
Routine vision exam (one every 24 months)	Nothing	Nothing	Nothing
Family planning services—office visits	Nothing	Nothing	Nothing
Outpatient Care			
Emergency room visits	$100 per visit (waived if admitted or for observation stay)	$100 per visit (waived if admitted or for observation stay)	$100 per visit (waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, nurse midwife, physician assistant, or nurse practitioner (billed by PCP)* • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care • Limited services clinic	 $10 per visit $25 per visit $10 per visit	 $15 per visit $25 per visit $10 per visit	 $20 per visit $25 per visit $10 per visit
Mental health or substance use treatment	$10 per visit	$10 per visit	$10 per visit
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	 Same as in-person visit $10 per visit	 Same as in-person visit $10 per visit	 Same as in-person visit $10 per visit
Chiropractors' office visits (up to 20 visits per calendar year)	$15 per visit	$15 per visit	$15 per visit
Acupuncture visits (up to 12 visits per calendar year)	$25 per visit	$25 per visit	$25 per visit
Short-term rehabilitation therapy—physical and occupational (up to 90 visits per calendar year**)	$15 per visit	$15 per visit	$15 per visit
Speech, hearing, and language disorder treatment—speech therapy	$15 per visit	$15 per visit	$15 per visit
Diagnostic X-rays and lab tests	Nothing	Nothing	Nothing
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date	$100 per category per service date	$100 per category per service date
Home health care and hospice services	Nothing	Nothing	Nothing
Oxygen and equipment for its administration	Nothing	Nothing	Nothing
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing	Nothing	Nothing
Prosthetic devices	20% coinsurance	20% coinsurance	20% coinsurance
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, nurse midwife, physician assistant, or nurse practitioner (billed by PCP)* • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	 $10 per visit*** $25 per visit***	 $15 per visit*** $25 per visit***	 $20 per visit*** $25 per visit***
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission	$150 per admission	$150 per admission
Inpatient Care (and maternity care)			
General hospital care (as many days as medically necessary)	$200 per admission	$400 per admission†	$400 per admission†
Chronic disease hospital care (as many days as medically necessary)	$200 per admission	$200 per admission	$200 per admission
Mental hospital or substance use facility care (as many days as medically necessary)	$200 per admission	$200 per admission	$200 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	Nothing	Nothing
Skilled nursing facility care (up to 45 days per calendar year)	Nothing	Nothing	Nothing

* For services by a physician assistant or nurse practitioner designated as primary care and not billed by the PCP, the Standard Tier PCP office visit cost share will be applied. If these providers are designated by the plan as specialty care, the specialist visit cost share will be applied.

** 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.

*** 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 for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
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	$10 for Tier 1 $25 for Tier 2 $50 for Tier 3	$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)**	$20 for Tier 1 $50 for Tier 2 $110 for Tier 3	$20 for Tier 1 $50 for Tier 2 $110 for Tier 3	$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.)	$300 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.)	$300 per calendar year per policy
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	$300 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.

002776226 (3/24) JB

MASSACHUSETTS

MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

SUMMARY OF BENEFITS

NETWORK BLUE® SELECT $250 DEDUCTIBLE

MIIA Town of Georgetown

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.**

This health plan includes a limited provider network called HMO Blue Select. It provides access to a network that is smaller than the Blue Cross Blue Shield of Massachusetts HMO Blue provider network. **In this plan, members have access to network benefits only from the providers in the HMO Blue Select network.** For help in finding which providers are included in the HMO Blue Select network, check the most current provider directory for your health plan option or visit the online provider search tool at **bluecrossma.com/findadoctor** and search for HMO Blue Select.

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 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 HMO Blue Select network of providers in Massachusetts. 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 within the HMO Blue Select network, 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 Select 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 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 and copayments for covered services. Your out-of-pocket maximum for medical benefits is **$2,500** per member (or **$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

Emergency 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 meeting your deductible, 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.

Service Area
The plan's service area includes all Massachusetts counties except Dukes, Barnstable, and Nantucket.

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.

Value Care Offering Coverage
Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

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
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 $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	$100 per visit after deductible (copayment 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	$15 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor for simple medical conditions • With the designated telehealth vendor for mental health services	Same as in-person visit $20 per visit, no deductible $15 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$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 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 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	Nothing after deductible**
Prosthetic devices	Nothing 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)	
General hospital care (as many days as medically necessary)	$300 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$200 per admission after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 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.)	$300 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.)	$300 per calendar year per policy
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	$300 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.

002776103 (03/24) LK

BlueCross® BlueShield®

MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

SUMMARY OF BENEFITS

PPO BLUE OPTIONS V.5

MIIA Town of Georgetown

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 includes a tiered provider network called PPO Blue Options v.5. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **bluecrossma.com/findadoctor** and search for PPO Blue Options v.5.

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

When You Choose Preferred Providers
You have the option of selecting in-network providers who are part of the PPO Blue Options network (preferred providers). You'll generally receive a higher level of benefits—and pay lower out-of-pocket costs—when you choose preferred providers. See the charts for your cost share.

Within the network, certain preferred primary care providers and preferred general hospitals are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier preferred providers each time you get care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier—**Includes preferred providers in Massachusetts that meet the standards for quality and are low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.

- **Standard Benefits Tier—**Includes preferred providers in Massachusetts that meet the standards for quality and moderate cost relative to our benchmark. This benefits tier includes preferred hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.

- **Basic Benefits Tier—**Includes preferred hospitals in Massachusetts that are high cost relative to our benchmark. Also includes preferred primary care providers in Massachusetts who did not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pocket costs when you choose providers in the Basic Benefits Tier.

Note: Primary care providers were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Preferred providers without sufficient data for cost and quality are placed in the Standard Benefits Tier. Preferred primary care providers that do not meet benchmarks for one or both of the domains and preferred hospitals that do not meet benchmarks for cost or that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your provider and the facility where your provider has admitting privileges before you choose a preferred primary care provider or receive care. For example, if you require hospital care and your Enhanced Benefits Tier preferred primary care provider refers you to an Enhanced Benefits Tier preferred hospital, you would pay the lowest cost sharing for both your provider and hospital services. Or, if your Enhanced Benefits Tier preferred primary care provider refers you to a Basic Benefits Tier preferred hospital for care, you will pay the lowest copayments for preferred primary care provider services, but the highest copayments for hospital services, except in an emergency.

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**

Note: In some out-of-state PPO service areas, different levels of preferred providers may not be available. In this case, your cost share will be the same as it would be for an Enhanced Benefits Tier preferred provider.

When You Choose Non-Preferred Providers
You can also obtain covered services from out-of-network providers (non-preferred providers), but your out-of-pocket costs are higher. See the charts for your cost share.

Your deductible is the amount of money you pay out-of-pocket each calendar year before you can receive coverage for certain out-of-network benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your out-of-network deductible is **$150** per member (or **$300** per family).

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

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a 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. See the chart for your cost share. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital.

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.

Value Care Offering Coverage
Your cost share may be waived or reduced for designated in-person and telehealth office visits for certain outpatient services. These services may include: primary care provider office visits; mental health or substance use treatment (including outpatient psychotherapy, patient evaluations, and medication management visits); chiropractor services; acupuncture services; or physical and/or occupational therapy services. See your benefit description (and riders, if any) for exact coverage details.

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 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	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exam (one every 24 months)	Nothing	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$100 per visit (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits, when performed by your PCP, nurse midwife, physician assistant, or nurse practitioner (billed by PCP):* – Enhanced Benefits Tier – Standard Benefits Tier – Basic Benefits Tier	 $10 per visit $15 per visit $20 per visit	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Specialists and other covered provider visits	$25 per visit	20% coinsurance after deductible
Mental health or substance use treatment	$10 per visit	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the in-network designated telehealth vendor	 Same as in-person visit $10 per visit	 Same as in-person visit Only applicable in-network
Chiropractors' office visits (up to 20 visits per calendar year)	$15 per visit	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	$25 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical, occupational, and speech (up to 90 visits per calendar year**)	$15 per visit	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing	20% coinsurance after deductible
Prosthetic devices	Nothing	20% coinsurance after deductible
Surgery and related anesthesia • In an office or health center, when performed by your PCP, nurse midwife, physician assistant, or nurse practitioner (billed by PCP)* – Enhanced Benefits Tier – Standard Benefits Tier – Basic Benefits Tier – Other covered providers • At an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	 $10 per visit*** $15 per visit*** $20 per visit*** $25 per visit*** $150 per admission	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Inpatient Care (including maternity care)		
General hospital care (as many days as medically necessary): – Enhanced Benefits Tier – Standard Benefits Tier – Basic Benefits Tier	 $200 per admission† $400 per admission† $400 per admission†	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	$200 per admission	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$200 per admission	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing	20% coinsurance after deductible

* For services by a physician assistant or nurse practitioner designated as primary care and not billed by the PCP, the Standard Tier PCP office visit cost share will be applied. If these providers are designated by the plan as specialty care, the specialist visit cost share will be applied.

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

*** 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)**	$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)**	$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 for reduced or 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.)	$300 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.)	$300 per calendar year per policy
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	$300 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.

002775942 (3/24) JB

Dental & Vision Insurance

Blue Cross Blue Shield of Massachusetts

Dental Blue Freedom

Blue 20/20 Vision (*new as of 2022*)

How do I make an informed decision?

The following pages will provide coverage information for the separate dental and vision insurance plans offered through the Town. While these documents provide a lot of important information about the plans, they should not be considered completely comprehensive. The carrier documents, provided through Blue Cross Blue Shield, are the only documents that coverage is based on. Please contact Blue Cross Blue Shield of Massachusetts if you have any questions at (800) 782-3675 or visit them online at bluecrossma.org

The 2025 eKit, which dives into greater detail on all of the insurance coverages, can be found using the following link or scanning the QR Code at the bottom of this page:

https://planinfo.bluecrossma.com/ekit/2024-miiatownofgeorgetown-en_US.pdf

MASSACHUSETTS

MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

SUMMARY OF BENEFITS

DENTAL BLUE® FREEDOM

MIIA Town of Georgetown

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 FREEDOM

For members under age 13, benefits 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	$25 Per Member/$75 Per Family Calendar-Year Deductible (in-network and out-of-network combined)	
Full Coverage	80% Coverage	50% Coverage
$1,500 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)		

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
- General anesthesia when administered in conjunction with covered surgical services
- Emergency dental care to treat acute pain or to prevent permanent harm to a member*

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

* Emergency care services are not subject to the calendar-year deductible.

WELCOME TO DENTAL BLUE FREEDOM,

A DENTAL PLAN DESIGNED TO MANAGE THE COST OF DENTAL SERVICES.

Your Dentist
Dental Blue Freedom offers a large network of dentists, including participating dentists in Massachusetts and nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

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
You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

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 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 benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year 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 Network Dentists Are Paid - Preferred Dentists
For dentists who have a preferred provider contract with Blue Cross Blue Shield, benefits are calculated based on the provisions of the preferred dentist's payment agreement and the dentist's allowed charge that is in effect at the time the covered dental service is provided. Preferred dentists agree to accept the allowed charge as payment in full. You pay your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year benefit maximum.

How Network Dentists Are Paid - Participating Dentists
For dentists who participate with Blue Cross Blue Shield, but do not have a Blue Cross Blue Shield preferred provider contract, benefits are calculated at the same benefit level that applies when the same covered dental services are provided by a preferred dentist. These dentists agree to accept the allowed charge as payment in full. You pay your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year benefit maximum.

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 or lifetime benefit maximum.

Supplemental Coverage - Non-participating Dentists Inside of Massachusetts
Your plan includes supplemental coverage to provide benefits for covered services received in Massachusetts from non-participating dentists. You may be responsible for the deductible and coinsurance (if applicable), and any difference between the maximum allowance and the dentist's actual charge, and all charges beyond your calendar-year or lifetime benefit maximum. See your plan sponsor for details and claim filing information.

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.

Accumulated Maximum Rollover Benefits
This dental plan includes an Accumulated Maximum Rollover Benefit. This rollover benefit allows you to roll over a certain dollar amount of your unused annual dental benefits for use in the future. There are limits and restrictions on this benefit. Refer to the Accumulated Dental Maximum Rollover brochure for further information.

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
Network 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 an out-of-network 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 payment only and does not assume financial risk for claims.

002775968 (3/24) JB

MASSACHUSETTS

DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

At Blue Cross Blue Shield of Massachusetts, we know that oral health is a critical part of overall health. That's why we offer a dental benefit that will allow you to roll over a portion of your unused dental benefits from year to year.

HOW MAXIMUM ROLLOVER WORKS

Beginning 60 days after the last day of your benefit period, your rollover amount will be added to your maximum benefit amount, increasing it for you to use that year and beyond (see below for amounts and maximums).

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

And, your rollover amount keeps growing and is available for you to use as long as your employer offers this rollover benefit.* The last column will show you the total amount of additional benefit dollars you can earn. It's one more way we're working to improve health care for all our members.

You can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures. This benefit applies to you automatically if:

- You receive at least one service during the benefit period
- You remain a member of the plan throughout the benefit period
- You don't exceed the claim payment threshold in the benefit period

If your dental plan's annual maximum benefit amount is:	And if your total claims don't exceed this amount for the benefit period:*	We'll roll over this amount for you to use next year and beyond:*	However, rollover totals will be capped at this amount:*
$500–$749	$200	$150	$500
$750–$999	$300	$200	$500
$1,000–$1,249	$500	$350	$1,000
$1,250–$1,499	$600	$450	$1,250
$1,500–$1,999	$700	$500	$1,250
$2,000–$2,499	$800	$600	$1,500
$2,500–$2,999	$900	$700	$1,500
$3,000 or more	$1,000	$750	$1,500

*This is not a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
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**).
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**).

002010701 50–0010 (3/23)

MASSACHUSETTS

BLUE 20/20 EXAM-PLUS VISION PLAN: ACCESS NETWORK

$130 – 24/12/24 Frequency

Vision care service	In-network member cost	Out-of-network reimbursement[1]
Comprehensive eye exam	$20 copay	up to $50
Contact lens fit and follow-up[2]		
• Standard	up to $55	n/a
• Premium	10% off retail price	n/a
Retinal imaging	up to $39	n/a
Enhanced Diabetes Eye Care Benefit[3] For members diagnosed with type 1 or type 2 diabetes	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	n/a
Frames	$130 allowance, then additional 20% off the balance	up to $74
Standard plastic lenses		
• Single vision	$25 copay	up to $42
• Bifocal	$25 copay	up to $78
• Trifocal	$25 copay	up to $130
• Lenticular	$25 copay	up to $130
• Standard progressive lens	$90 copay	up to $140
• Premium progressive lens	$90 copay, then 80% of charge less $120 allowance	up to $196
Lens options[2]		
• 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 for covered dependents under age 19	Paid in full	up to $26
• Standard anti-reflective coating	$45	n/a
• Photochromic/Transitions®´ plastic	20% off retail price	n/a
• Polarized	20% off retail price	n/a
• Other add-ons	20% off retail price	n/a
Contact lenses[4]		
• Conventional	$130 allowance, then additional 15% off the balance	up to $104
• Disposable	$130 allowance	up to $104
• Medically necessary	Paid in full	up to $210
Frequency		
• Exam	once every 24 months	
• Lenses for frames or one order of contact lenses	once every 12 months	
• Frames	once every 24 months	

For costs and further details about the coverage, including exclusions, refer to your member booklet.

1. Your actual expenses for covered services may exceed the stated out-of-network amount.
2. Indicates a service that is a discounted arrangement as part of your vision plan.
3. Consult with your eye care provider.
4. Discount applies to materials only and not to fittings for contact lenses.

ADDITIONAL IN-NETWORK SAVINGS AND DISCOUNTS

40%

OFF A COMPLETE SECOND PAIR OF GLASSES

20%

OFF NON-PRESCRIPTION SUNGLASSES

15%

OFF RETAIL PRICE OR 5% OFF PROMOTIONAL PRICE FOR LASER VISION CORRECTION THROUGH U.S. LASER NETWORK

Blue 20/20 is administered by EyeMed Vision Care®´, an independent company.

EyeMed

BENEFITS YOU CAN SEE—FROM A COMPANY YOU TRUST

ACCESS TO ONE OF THE NATION'S LARGEST VISION NETWORKS

THOUSANDS OF INDEPENDENT PROVIDERS

AWARD-WINNING CUSTOMER SERVICE

FAVORITE NATIONAL RETAILERS

LensCrafters®

PEARLE VISION℠

Target Optical®

and many regional retailers.

ONLINE SHOPPING OPTIONS

- Glasses.com
- Contactsdirect.com
- Ray-Ban.com
- Targetoptical.com
- Lenscrafters.com

SPECIAL OFFERS FOR ADDITIONAL SAVINGS

Find them at **blue2020ma.com**.

SAVE ON HEARING EXAMS AND HEARING AIDS

Offered by Amplifon Hearing, an independent company. To learn more about the savings available, visit **amplifonusa.com/blue2020**. To get started, call **1-866-921-5367**.

Questions?

Call customer service at **1-855-875-6948**.
To locate an in-network provider, visit **blue2020ma.com**.*

*Registration not required to search for providers.

001352457 55-0878 (1/22)

Mass. Deferred Compensation SMART Plan (457)

The Massachusetts Deferred Compensation (SMART Plan) allows employees to contribute pre-tax dollars into a retirement investment fund that will supplement their pension. Saving for the future is always a wise idea, and this fund pools the resources of the Commonwealth to take the stress out of investing. Employees can contribute a particular dollar amount every pay check, or a percentage of their total pay.

What are the benefits of contributing to the SMART Plan?

1. It lowers your current taxable income because you postpone paying taxes on contributions made to the SMART Plan.

2. It allows more of your money to work for you. This includes money that you ordinarily would have paid in federal income taxes. Tax-deferred compounding occurs when any earnings on your account are reinvested and given the chance to earn more money.

3. The contributions and any earnings that accumulate over the years are not taxed until you receive them. That's usually during retirement, when you may be in a lower tax bracket.

The SMART Plan is managed by Empower Retirement who offers convenient online and mobile access to track and change your investments.

For more information on the MA SMART Plan, please visit the following website or scan the QR Code at the bottom of this page:

https://mass-smart.empower-retirement.com/

AFLAC Coverage

Short Term Disability

What happens if you become sick or injured out of work and can't pay your bills? Do you have three to six months of salary saved in case of an injury or sickness? What if you miss a week, two months, or six months of work? Your paychecks will stop, but your bills won't. This will pay on top of PFML from the state. Customized for each person to fit your income and budget needs, and maternity leave is included.

Accident Indemnity

Up to 50% of the costs associated with an accident are non-medical and come out of your pocket in the form of co-pays, deductibles, travel, parking, medications, etc. AFLAC pays cash directly to you for accidents, on or off the job, and how you choose to use that money is up to you. Sprains, cuts, stitches, broken bones, burns, sports injuries, etc. Family coverage is available and great if you have young active kids.

Life Insurance

Everybody knows life insurance is important, but not necessarily where to get it. AFLAC provides term policies as well as whole, and once someone gets in the rate is locked. Experts say people should have 4-6 times salary in life insurance at the minimum. We don't require any physicals or blood tests to get coverage.

Cancer Protection

Did you know that 60% of the cost of cancer is non medical and comes in out of pocket expenses? Many people think that because they have health insurance they would be all set, but that isn't the case. Cancer is the #1 cause of bankruptcy in the US and it effects 1 in 2 men and 1 in 3 women. This benefit provides a tremendous amount of financial help in this situation.

Please contact our AFLAC agent Brandon Royce to get more information on how the plans work and to get quotes. Medical insurance is essential, but only pays medical bills. It doesn't have anything to do with paying everyday bills. That's where AFLAC comes in to pay you directly if you get hurt or sick and you can use that money towards your bills however you want.

Georgetown AFLAC Agent:

Brandon Royce

(617) 833-0139 – call or text (preferred)

Brandon_royce@us.aflac.com

Open Enrollment changes must be received by the Treasurer's Office on or prior to May 30, 2024 in order to be processed.

Please feel free to contact the Treasurer's Office at any time with any questions or concerns:

Alex Williams **AWilliams@GeorgetownMA.gov**

Town Hall – Collector's Office
1 Library Street
Georgetown, MA 01833

(978) 352-5723
Monday-Thursday 8am-4pm

Certain enrollment forms can be found on the Treasurer/Collector page of the Town's website:

www.georgetownma.gov

This document is intended to provide general information only. The plan documents available to registered users on the carrier websites are the documents that describe full and complete plan details. The carrier documents are the only documents that coverage is based on. Should you have a question about specific coverage, you will need to contact the carrier directly.