

TOWN OF LITTLETON

SUMMARY OF BENEFITS	MIIA Blue Care Elect Preferred PPO	
Key Features	In Network Benefits	Out of Network Benefits
Calendar Year Deductible		
Individual	None	\$250
Family	None	\$500
Out-of-Pocket Maximum		
Individual	None	\$ 1000 - co ins. Max
Family	None	\$ 2000 - co ins. Max
Lifetime Maximum		
Individual	None	None
Family	None	None
Physician's Office Services		
Primary Care Physician Office Visit	\$15	20% Co-Ins. After Deductible
Specialist Office Visit Copay	\$15	20% Co-Ins. After Deductible
Hospital Services		
Emergency Room Copay	\$ 100 ; waived if admitted	\$ 100; waived if admitted
Outpatient Surgery Copay	None	20% Co-Ins. After Deductible
Diagnostic X-Ray and Lab Service	No cost	20% Co-Ins. After Deductible
Rehabilitation Hospital Copay Number of treatment days	No cost 60 days	20% Co-Ins. After Deductible Combined with in-network
Skilled Nursing Facility Copay Number of treatment days	No cost 100 days	20% Co-Ins. After Deductible Combined with in-network
Physical Therapy, Occupational Therapy & Chiropractic Treatment		
Physical Therapy Visit Copay Number of allowed visits	\$15 100 days	20% Co-Ins. After Deductible
Occupational Therapy Visit Copay Number of allowed visits	\$15 100 days	20% Co-Ins. After Deductible
Chiropractic Services	\$15	20% Co-Ins. After Deductible
Mental Health Services		
In-patient treatment; biologically-based condition, Per admission copay Number of treatment days	None 60 day limit in a Mental Health & Substance abuse facility	20% Co-Ins. After Deductible Combined with in-network
Out-patient treatment; biologically-based condition, per visit Copay Number of allowed visits	\$15 24 visits per calender year	20% Co-Ins. After Deductible Combined with in-network
Pharmacy Services		
Retail Copay (30 day supply)		
Tier 1	\$10	Not applicable
Tier 2	\$25	Not applicable
Tier 3	\$50	Not applicable
Mail order Copay (90 day supply)		
Tier 1	\$20	Not applicable
Tier 2	\$50	Not applicable
Tier 3	\$100	Not applicable
Routine Vision Care		
Frequency of vision exams	1 per cal. Year	1 per cal. Year
Vision exam copay	\$15	20% Co-Ins. After Deductible

Over

Additional Services		
Infertility services	\$15 visit co-pay	20% Co-Ins. After Deductible
Other reproductive services including birth control and abortion services	\$15 visit co-pay	20% Co-Ins. After Deductible
Ambulance Service Copay	No cost for medically necessary transport	No cost for medically necessary transport
Durable Medical Equipment Benefit and Limitations (includes items such as oxygen, oxygen equipment, respiratory equipment, hospital beds, wheelchairs, canes, etc.)	\$1,500 per member per calendar year - No Cost in network	20% co-insurance and all charges beyond the calendar-year maximum
Benefit for Gym Membership	\$150 fitness benefit per membership per calendar year for fees paid for health club memberships or fitness classes at a health club. This one benefit includes any combination of fees incurred by all members enrolled under the plan.	\$150 fitness benefit per membership per calendar year for fees paid for health club memberships or fitness classes at a health club. This one benefit includes any combination of fees incurred by all members enrolled under the plan.

4/1/2008 for Plan year 6/1/2008-5/31/2009

