

**Town of Sherborn  
Employee HMO Plans Compared July 1, 2016**

2/4/2016

	<b>MIIA</b>	<b>MIIA</b>	<b>HARVARD PILGRIM</b>	<b>BLUE CROSS BLUE SHIELD</b>	<b>TUFTS HEALTH PLAN</b>	<b>FALLON COMMUNITY HEALTH PLAN SelectCare (SC) &amp; DirectCare (DC)</b>
	<b>BCBS Network Blue NE Value Plus</b>	<b>HMO BenchMark 250/750 deductible</b>	<b>HMO RATE SAVER</b>	<b>NETWORK BLUE NE OPTIONS TIERED NETWORK HMO RATE SAVER</b>	<b>EPO RATE SAVER (Navigator)</b>	<b>EPO RATE SAVER</b>
<b>BENEFIT</b>	<b>You Pay</b>	<b>You Pay</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
<b>Lifetime Benefit Maximum</b>	None	None	None	None	None	None
<b>Deductible</b>	None	\$250 individual/ \$750 family	None	None	None	None
<b>Out-of-Pocket (OOP) Maximum</b> - If applicable, once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for remainder of plan year.	<b>\$2,500 Individual \$5,000 Family per plan year... \$1,000 Individual \$2,000 Family RX limit</b>	<b>\$2,500 Individual \$5,000 Family per plan year... \$1,000 Individual \$2,000 Family RX limit</b>	\$2,000 Individual \$4,000 Family per plan year ...\$2,000 Individual \$4,000 Family Rx limit	\$2,000 Individual \$4,000 Family per plan year ...\$2,000 Individual \$4,000 Family Rx limit	\$2,000 Individual \$4,000 Family per plan year ...\$2,000 Individual \$4,000 Family RX limit	\$1,000 Individual \$2,000 Family per plan year ( Includes RX )
<b>Family Covered</b>	<b>Spouse; dependents; and adult children up to age 26</b>	<b>Spouse; dependents; and adult children up to age 26</b>	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
<b>General Hospital/ Mental Health admissions</b>				<b>\$250 co-pay per admission</b>		
<b>OUTPATIENT</b>						
<b>Emergency Room Visits for Emergency or Accident Care</b>	<b>\$75 copay (Inpatient copay applies if admitted)</b>	<b>\$100 co-pay after deductible</b>	\$75 copay	\$75 copay	\$75 copay	\$75 copay
<b>Outpatient Surgery in a Day Surgery facility or Hospital</b>	<b>\$125 copay</b>	<b>\$150 co-pay after deductible</b>	\$125 copay per outpatient surgery	Enhanced: \$150 copay Standard: \$250 copay Basic: \$250 copay Out-of-State copay \$150	\$125 copay per outpatient surgery	\$125 copay per outpatient surgery
<b>CT, MRI and Pet Scans</b>	<b>Nothing</b>	<b>\$100 co-pay after deductible</b>	Nothing	General Hospitals: Enhanced: \$75 copay Standard: \$150 copay Basic: \$150 Other Providers: \$75 copay	\$75 copay	Nothing

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<b>BENEFIT</b>	<b>You Pay</b>	<b>You Pay</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
<b>Physical Therapy</b>	\$15 copay per visit (up to 60 visits per calendar year)	\$20 co-pay up to 30 days per calendar year	\$20 copay (short-term); up to 90 consecutive days per condition	\$45 copay; up to 60 visits per calendar year	Speech and short-term PT/OT \$20 copay per visit; 30 visits per calendar year	\$20 copay; up to 20 visits per calendar year
<b>Office Visits Primary Care Physician</b>	\$15 copay per visit	\$20 copay for PCP	\$20 copay per visit	Enhanced: \$15 copay Standard: \$25 copay Basic \$45 copay Out-of-state copay \$15	\$20 copay per visit	\$20 copay per visit
<b>Preventive OV - PCP</b>	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
<b>Medical Care/Mental Health Care/Substance Abuse Care (Mental Health copays excluded from OOP max)</b>	\$15 copay per visit	\$15 copay per visit	\$20 copay per visit	Enhanced: \$15 copay Standard: \$25 copay Basic: \$45 copay Out-of-state copay: \$15 NOTE: Mental Health Care copay \$15	\$20 copay per visit	\$20 copay per visit
<b>Office Visits Specialist</b>	\$15 copay per visit	\$35 co-pay	\$35 copay per visit	\$45 copay per visit	\$35 copay per visit	\$35 copay per visit
<b>OB/GYN</b>	\$15 copay per visit	\$20 co-pay	\$20 copay per visit	\$45 copay per visit	\$20 copay per visit	\$20 copay per visit
<b>Diagnostic X-ray and Lab</b>	Nothing	Nothing after deductible	Nothing	Nothing	Nothing	Nothing
<b>Routine Vision Exam</b>	Nothing	Nothing (once every 24 months)	\$20 copay per visit; one visit per calendar year. \$0 copay for children under 5 years of age	\$0 copay; one visit every 24 months	\$20 copay per visit; one visit per calendar year  Eyewear discounts available at participating providers	\$0 copay per visit; one visit every 12 months

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<b>Dental Services</b>	Preventive dental for children under age 12. (Includes one initial oral exam, periodic oral exam, cleaning, fluoride treatment, and bitewing x-rays every 6 months.) Must be at a participating dental provider.	<b>NOT COVERED</b>	<b>Children under age 12</b> - Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	No coverage	<b>Children under age 12;</b> Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. <b>MUST</b> use participating dentist.	<b>Family dental coverage:</b> \$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.
<b>OTHER FEATURES</b>						
<b>Hospice Care</b>	Nothing	Nothing after deductible	Nothing	Nothing	Nothing	Nothing
<b>Durable Medical Equipment</b>	20% Coinsurance	Nothing after deductible	20% of HPHC cost	20% Coinsurance	80% Covered	Nothing

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<b>Chiropractor Visits</b> <i>(copays excluded from OOP max)</i>	<b>\$15 copay per visit</b>	<b>\$20 co-pay; 20 visits per calendar year</b>	\$35 copay per visit 12 visit maximum per calendar year	\$45 copay per visit. 12 visits maximum per calendar year	\$20 copay per visit; up to 12 visits per calendar year	\$20 copay per visit; up to 12 visits per calendar year not to exceed \$500 per calendar year.
<b>Prescription Drugs</b> <i>(Inpatient drugs paid in)</i>	<b>Retail Pharmacy</b> Tier 1: <b>\$10.00 copay</b> Tier 2: <b>\$25.00 copay</b> Tier 3: <b>\$45.00 copay</b> (up to a 30-day supply)  <b>Mail Order: (90 day supply)</b> Tier 1: <b>\$20.00 copay</b> Tier 2: <b>\$50.00 copay</b> Tier 3: <b>\$90.00 copay</b>	<b>Retail Pharmacy</b> Tier 1: <b>\$10.00 copay</b> Tier 2: <b>\$25.00 copay</b> Tier 3: <b>\$ 50.00 copay</b> (up to a 30-day supply)  <b>Mail Order: (90 day supply)</b> Tier 1: <b>\$20.00 copay</b> Tier 2: <b>\$50.00 copay</b> Tier 3: <b>\$ 110.00 copay</b>	<b>Retail Pharmacy:</b> Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$45.00 copay (up to a 30-day supply)  <b>Mail Order: (90 day supply)</b> Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$90.00 copay	<b>Retail Pharmacy:</b> Tier 1: \$15.00 copay Tier 2: \$30.00 copay Tier 3: \$50.00 copay (up to a 30-day supply)  <b>Mail Order: (90 day supply)</b> Tier 1: \$30.00 copay Tier 2: \$60.00 copay Tier 3: \$100.00 copay	<b>Retail Pharmacy:</b> Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$45.00 copay (up to a 30-day supply)  <b>Mail Order: (90 day supply)</b> Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$90.00 copay	<b>Retail Pharmacy:</b> Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$45.00 copay (up to a 30-day supply)  <b>Mail Order: (90 day supply)</b> Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$90.00 copay
<b>Fitness Benefit</b>			<b>Reimbursement</b>	<b>Reimbursement</b>	<b>Reimbursement</b>	<b>Reimbursement</b>
	<p>Up to \$150 reimbursement per subscriber toward membership at health club, fitness facility or gym per calendar year.</p> <p>Up to \$150 reimbursement per subscriber toward Weight Watchers or hospital based weight loss program per calendar year.</p>	<p>Up to \$150 reimbursement per subscriber toward membership at health club, fitness facility or gym per calendar year.</p>	<p>Fitness reimb up to <b>\$150</b> per subscriber at a Health &amp; Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.</p> <p>Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®</p>	<p>Up to <b>\$300</b> reimbursement toward membership or exercise classes at a health club. See plan materials for details.</p> <p>Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to \$150 per calendar year toward your program fees.</p>	<p>Fitness reimb up to <b>\$150</b> per subscriber at a Health &amp; Fitness club, including exercise classes per calendar year. See plan materials for details.</p> <p>JENNY CRAIG DISCOUNTS:                      -FREE 30 DAY PROGRAM                      -25% OFF A PREMIUM/METABOLIC PROGRAM                      NUTRISYSTEM DISCOUNT:                      -12% DISCOUNT - OFF CURRENT PROMO                      -CORE OR SELECT PROGRAM</p>	<p>It Fits! Program reimburses families up to <b>\$400</b> per family contract (<b>\$200</b> for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment. The equipment must be new, purchased from a retail store and not Craig's List or EBay. Direct Care It Fits reimbursement <b>\$250 / 500.</b></p>