

**TOWN OF NATICK PLAN COMPARISON OF WSHG AND GIC INDEMNITY PLANS**

<b>Plan Design Feature</b>	<b>WSHG HPHC PPO</b>	<b>WSHG TUFTS POS</b>	<b>UniCare State Indemnity Plan/Basic (With CIC) Indemnity</b>
<b>Key Cost Features</b>			
Monthly Premium			
Individual	\$1,206.00	\$1,206.00	\$767.55
Family	\$2,680.00	\$2,680.00	\$1,791.79
Calendar Year Deductible for Non-Network			
Individual	\$100	\$100	N/A
Family	\$200	\$200	N/A
Co-insurance Out of Network	20%	20%	N/A
Out-of-Pocket Maximum			
Individual	\$1,600	\$1,500	\$750; Applies to home health care, prosthetics, braces and allergy serum
Family	\$3,200	\$3,000	N/A
Lifetime Maximum			
Individual	None	None	None
Family	None	None	None
<b>Services Provided In A Physician's Office</b>			
Primary Care Physician Office Visit			
***Tier 1 (Excellent)	\$5	\$5	\$10
**Tier 2 (Good)	No tiering	No tiering	\$25
*Tier 3 (Standard)	No tiering	No tiering	\$30
Specialist Office Visit			
***Tier 1 (Excellent)	\$5	\$5	\$15
**Tier 2 (Good)	No tiering	No tiering	\$25
*Tier 3 (Standard)	No tiering	No tiering	\$35
<b>Services Provided In A Retail Clinic</b>			
Outpatient Visit			\$15
<b>Services Provided In A Hospital Setting</b>			
Emergency Room	\$40 copay	\$25 copay	\$75 copay
Waived, if admitted?	Yes	Yes	Yes
Per Admission			
Tier 1	Covered in Full	Covered in Full	\$200 copay
Tier 2	No tiering	No tiering	No tiering
Tier 3	No tiering	No tiering	No tiering
Limits on number of copays	N/A	N/A	One admission copay for during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge

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Outpatient Surgery	Covered in Full	Covered in Full	\$100 copay
Limits on number of copays	N/A	N/A	One outpatient surgery copay per quarter of the year
Diagnostic X-Ray and Lab Service	Covered in Full	Covered in Full	\$75 copay for high-tech imaging services (MRI, CT, PET Scan) Max. of one copay per member/per day; No copay for routine X-Rays and labs
Rehabilitation Hospital			\$150
Benefit Limits			No limits
Skilled Nursing Facility	Covered in Full	Covered in Full	20%
Benefit Limits	Up to 100 days per year	Up to 100 days per year	45 days
<b>Physical Therapy, Occupational Therapy &amp; Chiropractic Treatment</b>			
Physical Therapy	\$5 copay	\$5 copay	\$15 copay
Benefit Limits	Up to 90 consecutive days per condition	Up to 60 consecutive days per condition	None
Occupational Therapy	\$5 copay	\$5 copay	\$15 copay
Benefit Limits	Up to 90 consecutive days per condition	Up to 60 consecutive days per condition	None
Chiropractic Services	\$5 copay	\$5 copay	20% coinsurance
Benefit Limits	Up to \$500 per calendar year	Up to 12 visits per calendar year	20 visits per year
<b>Mental Health Services</b>			
In-patient treatment; biologically-based illness	Covered in Full	Covered in Full	\$150 per quarter inpatient copay
Benefit Limits	Unlimited number of days	Unlimited number of days	None
Out-patient treatment; biologically-based illness	\$5 copay	\$5 copay	\$15 for individual/family therapy; \$10 for medication management; \$10 for group therapy
Benefit Limits	Unlimited visits	Unlimited visits	Unlimited visits
<b>Pharmacy Services</b>			
Retail Copay (up to 30 day supply)			
Tier 1	\$5	\$5	\$10
Tier 2	\$10	\$10	\$25
Tier 3	\$25	\$25	\$50
Mail order Copay (up to 90 day supply)			
Tier 1	\$10	\$10	\$20
Tier 2	\$20	\$20	\$50
Tier 3	\$75	\$50	\$110
Separate pharmacy deductibles.	No		

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Does this plan include or require any unique pharmacy management features (mandatory use of generics, step therapies, mandatory specialty drug program)?			
<b>Routine Vision Care</b>			
Does plan cover vision exams?	Yes	Yes	Yes
Frequency of vision exams	One visit every 12 months	One visit per calendar year	Once every 24 months
Copay for a vision exam.	\$5	\$5	Ophthalmologist: Tier 1 \$20; Tier 2 \$25; Tier 3 \$40; Optometrist copay: \$25
<b>Hearing Aids</b>			
Does the plan cover hearing aids?	No	No	Yes
Hearing aid benefit			Every two years plan pays for first \$500 of expense and 20% coinsurance of next \$1,500
Ambulance Service Copay	No copay	No copay	Covered in Full
Gym Membership Benefit	\$150 per year per subscriber	\$150 per year per subscriber	Not Covered

*The information contained in this spreadsheet is for illustrative purposes only and based on publicly available information. The detailed plan design information for the Group Insurance Commission (GIC) plans and/or the municipal plan(s) has not been approved by either the GIC or the GIC's insurance carriers or by the municipality or the municipality's insurance carriers. With respect to the GIC benefits shown, complete information about specific benefits is contained in the "Summary Plan Descriptions" (known as the GIC's health plans' "Plan Handbooks") for each program, which are available from the GIC. More detailed information about a municipality's plan may be obtained from the municipality. Boston Benefit Partners, LLC does not represent or warrant that th*