

TOWN OF NATICK PLAN COMPARISON OF WSHG NETWORK BLUE PLANS

*****Blue Cross is not part of the Group Insurance Commission offerings at this time. Only a comparison to the WSHG Rate Saver plan is shown below.*****

Plan Design Feature	WSHG NETWORK BLUE HMO	WSHG NETWORK BLUE RATE SAVER PLAN
Key Cost Features		
Monthly Premium		
Individual	\$651.00	\$537.00
Family	\$1,747.00	\$1,441.00
Calendar Year Deductible		
Individual	None	None
Family	None	None
Out-of-Pocket Maximum		
Individual	None	None
Family	None	None
Lifetime Maximum		
Individual	None	None
Family	None	None
Services Provided In A Physician's Office		
Primary Care Physician Office Visit		
***Tier 1 (Excellent)	\$5 copay	\$15
**Tier 2 (Good)	No tiering	\$25
*Tier 3 (Standard)	No tiering	\$45
Specialist Office Visit		
***Tier 1 (Excellent)	\$5 copay	\$45
**Tier 2 (Good)	No tiering	No tiering
*Tier 3 (Standard)	No tiering	No tiering
Services Provided In A Retail Clinic		
Outpatient Visit		
Services Provided In A Hospital Setting		
Emergency Room	\$25 copay	\$100 copay
Waived, if admitted?	Yes	Yes
Per Admission		
Tier 1	Covered in Full	\$250 copay
Tier 2	No tiering	\$500 copay
Tier 3	No tiering	\$1000 copay
Limits on number of copays	N/A	
Outpatient Surgery	Covered in Full	\$150/\$250/\$500
Limits on number of copays	N/A	
Diagnostic X-Ray and Lab Service	Covered in Full	\$75/150/250 copay for high-tech diagnostic imaging (CAT/MRI/PET)
Rehabilitation Hospital		
Benefit Limits		
Skilled Nursing Facility		
Benefit Limits	Covered in Full Up to 100 days per year	Covered in Full Up to 100 days per year

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Physical Therapy, Occupational Therapy & Chiropractic Treatment		
Physical Therapy	\$5 copay	\$45 copay
Benefit Limits	Up to 60 visits per calendar year	Up to 60 visits per calendar year
Occupational Therapy	\$5 copay	\$45 copay
Benefit Limits		
Chiropractic Services	No coverage	\$45 copay
Benefit Limits		Up to 12 visits per calendar year
Mental Health Services		
In-patient treatment; biologically-based illness	Covered in Full	\$250/500/1000 copay
Benefit Limits	Unlimited number of days	Unlimited number of days
Out-patient treatment; biologically-based illness	\$5 copay	\$15 copay
Benefit Limits	Unlimited visits	Unlimited visits
Pharmacy Services		
Retail Copay (up to 30 day supply)		
Tier 1	\$5	\$15
Tier 2	\$10	\$30
Tier 3	\$25	\$50
Mail order Copay (up to 90 day supply)		
Tier 1	\$5	\$30
Tier 2	\$10	\$60
Tier 3	\$25	\$100
Separate pharmacy deductibles.	No	
Does this plan include or require any unique pharmacy management features (mandatory use of generics, step therapies, mandatory specialty drug program)?		
Routine Vision Care		
Does plan cover vision exams?	Yes	Yes
Frequency of vision exams	One visit every 12 months	One visit every 24 months
Copay for a vision exam.	\$5	\$45
Hearing Aids		
Does the plan cover hearing aids?	No	No
Hearing aid benefit		
Ambulance Service Copay	No copay	No copay
Gym Membership Benefit	\$150 per year per family	\$150 per year per family

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