

TIER PLANS BENEFIT SUMMARY*
ACTIVE EMPLOYEES HEALTH INSURANCE PLANS – JULY 1, 2016 - NON-SETTLED

BENEFIT	CITY OF WORCESTER DIRECT	CITY OF WORCESTER ADVANTAGE		BCBS NETWORK BLUE NEW ENGLAND	BCBS BLUE CARE ELECT PREFERRED Those Residing out of New England only	
		Tier 1	Tier 2		In Network	Out of Network
Deductible	\$200 Ind/\$600 Fam	\$250 Ind/\$750 Fam		\$250 Ind/\$750 Fam T2 & T3 Only	\$250 Ind/\$750 Fam	
Out of Pocket Maximum	\$1,500 Ind/\$3,000 Fam – Med \$1,500 Ind/\$3,000 Fam - Rx	\$2,000 Ind/\$4,000 Fam – Med \$1,500 Ind/\$3,000 Fam - Rx		\$2,500 Ind/\$5,000 Fam – Med \$1,500 Ind/\$3,000 Fam - Rx	\$3,000 Ind/\$6,000 Fam – Med \$1,500 Ind/\$3,000 Fam - Rx	
Wellness Visit	\$0	\$0		\$0	\$0	20% co-ins after deductible
PCP Office Visit	\$15	\$15	\$20	T1: \$15 T2: \$25 T3: \$35	\$35	20% co-ins after deductible
Specialist Visit	\$25	\$25	\$30	\$35	\$35	20% co-ins after deductible
Prescriptions	Retail = \$10/\$25/\$45 30-Day Supply Mail-away = \$20/\$50/\$135 90-Day Supply	Retail = \$10/\$25/\$45 30-Day Supply Mail-away = \$20/\$50/\$135 90-Day Supply		Retail = \$10/\$25/\$45 30-Day Supply Mail-away = \$20/\$50/\$135 90-Day Supply	Retail = \$10/\$25/\$45 30-Day Supply Mail-away = \$20/\$50/\$135 90-Day Supply	
Inpatient Hospital	\$200 after deductible	\$250 after deductible	\$500 after deductible	T1: \$150 T2: \$150 T3: \$500 T1: 0 deductible T2 & T3: after deductible	10% co-in after deductible	30% co-in after deductible
Outpatient Surgery	\$100 after deductible	\$150 after deductible	\$300 after deductible	Surgical day care facility – T1: \$150 T2: \$150 T3: \$500 Ambulatory surgical facility - \$150 T1: 0 deductible T2 & T3: after deductible	Office setting \$35 Ambulatory surgical facility - \$300 per admits	20% co-ins after deductible
Diagnostic Services Lab, X-ray, etc.	Covered in full (after deductible)	Covered in full (after deductible)		T1: Nothing T2: Nothing after deductible T3: Nothing after deductible	10% co-ins after deductible	30% co-ins after deductible
CT scans, MRIs, PET scans Hospital Setting	\$50 (non-hospital setting) or \$100 (hospital setting) after deductible for MRIs, PET, and CAT scans	\$50 (non-hospital setting) or \$100 (hospital setting) after deductible for MRIs, PET, and CAT scans		T1: \$50 per category, per date of service T2: \$50 per category, per date of service after deductible T3: \$450 per category, per date of service after deductible	10% co-ins after deductible	30% co-ins after deductible
Short-term Rehab: Outpatient, OT, PT	\$15 co-pay (after deductible) 60 visits per plan year	\$20 co-pay (after deductible) 60 visits per plan year		\$35 per visit (Up to 60 per CY year)	\$35 per visit No deductible (up to 100 visits per CY)	20% co-in after deductible (up to 100 visits per CY)
Skilled Nursing	Covered in full Up to 100 days per plan year (after deductible)	Covered in full Up to 100 days per plan year (after deductible)		Covered in full (Up to 100 days per CY year)	10% co-ins after deductible (Up to 100 days per CY)	30% co-ins after deductible Up to 100 days per CY)
Chiropractor	\$15 per visit (up to 12 visits per plan year)	\$20 per visit (up to 12 visits per plan year)		\$35 per visit	\$35 per visit	20% co-ins after deductible
Outpatient Mental Health	\$15 co-payment per visit	\$15 co-payment per visit		\$15 per visit	\$35 per visit	20% co-ins after deductible
Durable Medical Equipment (wheelchairs, crutches, etc.)	20% co-insurance (after deductible)	20% co-insurance (after deductible)		20% co-insurance	20% co-ins	40% co-ins (after deductible)
ER Visit - Waived if Admitted	\$100	\$100		\$100	\$150	\$150
Ambulance	Medically necessary are covered in full (after deductible), or when ordered by a physician	Medically necessary are covered in full (after deductible), or when ordered by a physician		Medically necessary are covered in full or when ordered by a physician (no deductible)	For emergency : 10% co-ins (no deductible) Medical necessary: 10% co-ins (after deductible)	For emergency: 10% co-ins (no deductible) Medically necessary: 30% co-ins (after deductible)
PREMIUM RATES Mo. Prem. Indiv/Fam	\$573.40/\$1,456.91	\$716.24/\$1,778.30		\$872.45/\$2,255.60	\$916.53/\$2,369.85	
Employee Weekly Cost	Ind: \$33.08 Fam: \$84.05	Ind: \$41.32 Fam: \$102.59		Ind: \$50.33 Fam: \$130.13	Ind: \$52.88 Fam: \$136.72	
Monthly Cost	Ind: \$143.35 Fam: \$364.23	Ind: \$179.06 Fam: \$444.58		Ind: \$218.11 Fam: \$563.90	Ind: \$229.13 Fam: \$592.46	

* This is a brief summary of some of the benefits offered. Additional details can be found in the complete plan descriptions.