

TIER PLANS BENEFIT SUMMARY*
NON-REPRESENTED ACTIVE EMPLOYEES HEALTH INSURANCE PLANS – JULY 1, 2011

BENEFIT	CITY OF WORCESTER DIRECT	CITY OF WORCESTER ADVANTAGE		BCBS NETWORK BLUE NEW ENGLAND
		Tier 1	Tier 2	
Deductible	\$200 Ind/\$600 Fam	\$250 Ind/\$750 Fam		\$250 Ind/\$750 Fam
Out of Pocket Maximum	\$1,500 Ind/\$3,000 Fam	\$2,000 Ind/\$4,000 Fam		\$2,500 Ind/\$5,000 Fam
Wellness Visit	\$0	\$0		\$0
PCP Office Visit	\$15	\$15	\$20	T1: \$15 T2: \$25 T3: \$35
Specialist Visit	\$25	\$25	\$30	\$35
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
Inpatient Hospital	\$200 after deductible	\$250 after deductible	\$500 after deductible	T1: \$150 T2: \$150 T3: \$500
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
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
CT scans, MRIs, PET scans	\$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 & T2: \$50 per category, per date of service T3: \$450
Short-term Rehab: Outpatient, OT, PT	\$15 co-pay (after deductible) 60 visits per benefit year	\$20 co-pay (after deductible) 60 visits per benefit year		\$35 per visit Up to 60 per calendar year
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 calendar year
Chiropractor	\$15 per visit (up to 12 visits per plan year)	\$20 per visit (up to 12 visits per plan year)		\$35 per visit
Outpatient Mental Health	\$15 co-payment per visit	\$15 co-payment per visit		\$15 per visit
Durable Medical Equipment (wheelchairs, crutches, etc.)	20% co-insurance (after deductible)	20% co-insurance (after deductible)		All charges beyond \$750 Calendar-year benefit maximum
ER Visit - Waived if Admitted	\$100	\$100		\$100
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 (referral is needed)
PREMIUM RATES Mo. Prem. Indiv/Fam	\$439.78/\$1,117.41	\$544.17/\$1,339.12		\$638.94/\$1,652.49
Employee Weekly Cost	Ind: \$25.37 Fam: \$64.47	Ind: \$31.39 Fam: \$77.26		Ind: \$36.86 Fam: \$95.34
Monthly Cost	Ind: \$109.95 Fam: \$279.35	Ind: \$136.04 Fam: \$334.78		Ind: \$159.74 Fam: \$413.12

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