CITY OF SOMERVILLE AND GIC MEDICAL PLAN COMPARISON (AS OF JULY 1, 2010)

Indemnity, PPO Options For Employees and Non-Medicare Retirees & Survivors:

	City Plans			*Group Insurance Commission Plans*								
	BCBS Major Medical	BCBS Blue Care Elect		Harvard Pilgrim Health Care Independence Plan		Tufts Health Plan Navigator		UniCare State Indemnity Plan/Community Choice	UniCare State Indemnity Plan/Basic (With CIC)	UniCare State Indemnity Plan/PLUS		
Plan Type	Indemnity	PPO		PPO		PPO		PPO-type	Indemnity	PPO-type		
Coverage Area Not Available In These Counties	Available in all counties	Available in all counties		Available throughout Massachusetts, Maine, Rhode Island and New Hampshire; limited availability - Connecticut, Vermont, New York		Available throughout Massachusetts and Rhode Island; limited availability in Connecticut, New Hampshire, New York, Vermont		Available throughout Massachusetts.	Available throughout the U.S. and outside of the country	Available throughout Massachusetts, Maine, New Hampshire, Rhode Island; limited availability in Connecticut		
Key Cost Features	Effective 10/1/2010			Effective 7/1/10 - Full Cost Rates Including 0.33% Administrative Fee								
Monthly Premium												
Individual	$1,030.50	$882.93		$604.99		$581.80		$407.96	$806.51	$562.84		
Family	$2,578.40	$2,209.03		$1,477.75		$1,412.66		$979.09	$1,882.97	$1,343.22		
	No Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	No Network	No Network	In-Network	In-Net/ Outside MA	Out-of-Network
Calendar Year Deductible				*Note: Deductibles for mental health and substance abuse services accumulate separately from the deductibles for other medical services*								
Individual	$50 Extended Benefit	None	$250	$250	$150 outpatient; Emergency room services do not apply	$250	$150	$250	$250	$250		$100
Family	$100 Extended Benefit	None	$500	$750	$300 outpatient; Emergency room services do not apply	$750	$300; Two members of a family must satisfy a $150 member ded.	$750	$750	$750		$200
Out-of-Pocket Maximum												
Individual	$100,000 extended benefit lifetime maximum per member	None	$1,000	None	$3,000; Doesn't include copays for office visit, hospital, ER, drugs or for skilled nursing facility coins.	None	$3,000	$750; Applies to home health care, prosthetics, braces and allergy serum	$750; Applies to home health care, prosthetics, braces and allergy serum	$750; Applies to home health care, prosthetics, braces and allergy serum		$3,000
Family	See above	None	$2,000	N/A	N/A	N/A	$3,000	N/A	N/A	N/A		N/A
Lifetime Maximum												
Individual	See OOP Maximum	None	None	None	None	None	None	None	None	None		None
Family		None	None	None	None	None	None	None	None	None		None
Physician's Office Services												
Primary Care Physician Office Visit Copay												
Tier 1 (Excellent)	20% coinsurance after EB annual deductible (No copayment for well-child care exams, routine adult physical, routine GYN, routine hearing exams, routine vision and routine family planning)	$10 copay (No copayment for well-child care exams, routine adult physical, routine GYN, routine hearing exams, routine vision, routine family planning services)	20% coinsurance after annual deductible	$20 copay	20% after annual deductible	$20 copay	20% after annual deductible	$15 copay	$15 copay	$15 copay		20% coinsurance after the applicable O.V. copay, per visit, and after the annual CY ded.
Tier 2 (Good)	No tiering	No tiering	No tiering	No tiering	20% after annual deductible	No tiering	20% after annual deductible	$30 copay	$30 copay	$30 copay	Only MA. Doctors tiered; outside MA., 100% coverage after $30 copay	20% coinsurance after the applicable O.V. copay, per visit, and after the annual CY ded.
Tier 3 (Standard)	No tiering	No tiering	No tiering	No tiering	20% after annual deductible	No tiering	20% after annual deductible	$35 copay	$35 copay	$35 copay		20% coinsurance after the applicable O.V. copay, per visit, and after the annual CY ded.

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	No Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	No Network	No Network	In-Network	In-Net/ Outside MA	Out-of-Network
Physician's Office Services Continued Specialist Care Physician Office Visit Copay Tier 1 (Excellent)	20% coinsurance after EB annual deductible	$10 copay	20% coinsurance after annual deductible	$20 copay	20% after annual deductible	$25 copay	20% after annual deductible	$25 copay	$20 copay	$25 copay		20% coinsurance after the applicable O.V. copay, per visit, and after the annual CY ded.
Tier 2 (Good)	No tiering	No tiering	No tiering	$35 copay	20% after annual deductible	$35 copay	20% after annual deductible	$30 copay	$30 copay	$30 copay	Only MA. Doctors tiered; outside MA., 100% coverage after $30 copay	20% coinsurance after the applicable O.V. copay, per visit, and after the annual CY ded.
Tier 3 (Standard)	No tiering	No tiering	No tiering	$45 copay	20% after annual deductible	$45 copay	20% after annual deductible	$45 copay	$40 copay	$45 copay		20% coins. after the applicable O.V. copay, per visit, and after the annual CY ded.
Services provided in a Retail Clinic Outpatient Visit	20% coinsurance after EB annual deductible	$10 copay	N/A	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay		$20 copay
Hospital Services Emergency Room	Covered in full	$50 copay	$50 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay		$100 copay
Copay Waived if Admitted?	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Per Admission Tier 1	Covered in full after $25 deductible per admission	Covered in full	20% coins. after annual ded.	$250 copay	20% after annual deductible	$300 copay	20% after annual deductible	$250 copay	$200 copay	$250 copay		$500 copay plus 20% coinsurance
Tier 2	No tiering	No tiering	No tiering	$500 copay	20% after annual deductible	$700 copay	20% after annual deductible	N/A	N/A	$500 copay		
Tier 3	No tiering	No tiering	No tiering	$750 copay	20% after annual deductible	N/A	20% after annual deductible	N/A	N/A	$750 copay		
Copay Limits	N/A	N/A	N/A	Maximum of four copays per calendar year; Waived if readmitted within 30 days	None	Maximum of four copays per calendar year; Waived if readmitted within 30 days	None	One admission copay during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge	One admission copay for during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge	One admission copay during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge		None

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	No Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	No Network	No Network	In-Network	In-Net/ Outside MA	Out-of-Network
Hospital Services Continued												
Outpatient Surgery	No copay	No copay	20% coinsurance after annual deductible	$150 copay	20% after annual deductible	$150 copay	20% after annual deductible	$110 per incidence; no more than one per quarter	$110 per incidence; no more than one per quarter	$110 copay (Tier1) $250 copay (Tier2) $250 copay (Tier3)		$110 copay then 20% coinsurance
Copay Limits	N/A	N/A	N/A	Four copays per calendar year	None	Four copays per calendar year	None	One outpatient surgery copay per quarter of the year	One outpatient surgery copay per quarter of the year	One outpatient surgery copay per quarter of the year		None
Diagnostic X-Ray and Lab Service	No copay	No copay	20% coinsurance after annual deductible	$100 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	20% after annual deductible	$100 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	20% after annual deductible	$100 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	$100 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	$100 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		20% after annual deductible
Rehabilitation Hospital	Covered in full after $25 deductible per admission	No copay	20% coins. after annual ded.	No copay	20% after annual deductible	No copay	20% after annual deductible	$200 copay	$150 copay	$200 copay		$400 copay then 20% coinsurance
Benefit Limits	No limit	60 days combined per calendar year		No limits	No limits	No limits	No limits	No limits	No limits	No limits		No limits
Skilled Nursing Facility Copay	Covered in full after $25 deductible per admission	No copay	20% coins. after annual ded.	20%	20% after annual deductible	20% copay	20% after annual deductible	20%; Does not count toward the annual out-of-pocket maximum	20%	20%; Does not count toward the annual out-of-pocket maximum		
Benefit Limits	No limit	Up to 100 days combined per calendar year		45 days; Combined in and out of network limit		45 days; Combined in and out of network limit		45 days; Combined in and out of network limit	45 days	45 days; Combined in and out of network limit		
Physical Therapy & Occupational Therapy												
Physical Therapy	No cost at hospital or health center; 20% coinsurance after EB annual deductible for physician services	$10 copay	20% coinsurance after annual deductible	$20 copay	20% after annual deductible	$20 copay	20% after annual deductible	$15 copay	$20 copay	$15 copay		$15 copay
Annual Visit Limits	No limit	Up to 100 days combined with Occupational therapy per calendar year		Up to 90 consecutive days following illness or injury		30 visits per calendar year		None	None	None		None
Occupational Therapy	No cost at hospital or health center; 20% coinsurance after EB annual deductible for physician services	$10 copay	20% coinsurance after annual deductible	$20 copay	20% after annual deductible	$20 copay	20% after annual deductible	$15 copay	$20 copay	$15 copay		$15 copay
Annual Visit Limits	No limit	Up to 100 days combined with physical therapy per calendar year		Up to 90 consecutive days following illness or injury		30 visits per calendar year		None	None	None		None
	No Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	No Network	No Network	In-Network	In-Net/ Outside MA	Out-of-Network
Chiropractic Services												
Chiropractic Office Visit	20% coinsurance after EB annual deductible for physician services	$10 copay	20% coinsurance after annual deductible	$20 copay	20% after annual deductible	$20 copay	20% after annual deductible	$15 copay then 20% coinsurance; $40 maximum reimbursement per visit	20% coinsurance	$20 copay then 20% coinsurance; $40 maximum reimbursement per visit		

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Annual Visit Limits	No limit	20 visits per calendar year		20 visits per year	20 visits per year	20 visits per year	20 visits per year	20 visits per year	20 visits per year	20 visits per year		
Mental Health Services												
Separate Mental Health Deductible	No	No	No	None	Yes	None	Yes	Yes	Yes	None		Yes
Mental Health Calendar Year deductible	N/A	N/A	N/A	None	$150, Single $300, Family	None	$150, Single $300, Family	None	$150, single $300, family	None		$150, Single $300, Family
Mental Health Out of Pocket Maximum	N/A	N/A	N/A	$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family		$3,000 per member
In-patient treatment	No copay	No copay	20% coinsurance after annual deductible	$200 copay; Maximum of four copays per year	$150 copay then 20% copayment after annual deductible	$200 copay; Maximum of four copays per year	$150 copay then 20% copayment after annual deductible	$200 copay; Maximum of four copays per year	$150 per quarter inpatient copay	$200 copay; Maximum of four copays per year		$150 copay then 20% copayment after annual deductible
Annual Visit Limits	No limit	No limit	No limit	None	None	None	None	None	None	None		None
Out-patient treatment	No copay	$10 copay	20% coinsurance after annual deductible	$15 for group visits; $20 for individual visits	20% after deductible for visits 1-15; 50% after	$20 for individual/family; $15 for medication management;	20% after deductible for visits 1 through 15, 50%	$20 for individual/family; $15 for medication management; $15 for group therapy	$20 for individual/family therapy; $15 for medication management; $15 for group therapy	$20 for individual/family; $15 for medication management;		20% for visits 1-15; 50% for visits 16+
Annual Visit Limits	No limit	No limit	No limit	None	None	None	None	None	None	None		None
Pharmacy Services												
Retail Copay (30 day supply)												
Tier 1	20% coinsurance for all meds; deductible does not apply	$10	No Benefit	$10	No Benefit	$10	No Benefit	$10	$10	$10		No Benefit
Tier 2		$20	No Benefit	$25	No Benefit	$25	No Benefit	$25	$25	$25		No Benefit
Tier 3		$35	No Benefit	$50	No Benefit	$50	No Benefit	$50	$50	$50		No Benefit
Mail order Copay (90 day supply)												
Tier 1	$5	$10	No Benefit	$20	No Benefit	$20	No Benefit	$20	$20	$20		No Benefit
Tier 2	$10	$20	No Benefit	$50	No Benefit	$50	No Benefit	$50	$50	$50		No Benefit
Tier 3	N/A	$35	No Benefit	$110	No Benefit	$110	No Benefit	$110	$110	$110		No Benefit
Routine Vision Care												
Coverage	No	Yes	Yes	Yes		Yes		Yes	Yes	Yes		
Frequency	N/A	once every 24 months		Once every 24 months		Once every 24 months		Once every 24 months	Once every 24 months	Once every 24 months		
Member Responsibility	All charges	$10 copay	20% coinsurance after annual deductible	Ophthalmologist: Tier 1 $20; Tier 2 $35; Tier 3 $45;	20% after annual deductible	Ophthalmologist: Tier 1 $25; Tier 2 $35; Tier 3 $45	20% after annual deductible	Ophthalmologist: Tier 1 $25; Tier 2 $30; Tier 3 $45; Optometrist copay: $30	Ophthalmologist: Tier 1 $20; Tier 2 $30; Tier 3 $40; Optometrist copay: $30	Ophthalmologist: Tier 1 $25; Tier 2 $30; Tier 3 $45; Optometrist copay: $30		
	No Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	No Network	No Network	In-Network	In-Net/ Outside MA	Out-of-Network
Additional Services												
Does plan cover infertility services?	Yes	Yes	Yes	Yes		Yes		Yes	Yes	Yes		
Frequency limitations on infertility services	Lifetime limit of 6 medicated cycles per person for any ART	Up to 6 ART cycles per person per lifetime		Lifetime limit of 5 ART cycles per person		When approved in advance covers a maximum of 5 ART cycles per person, per lifetime		Maximum lifetime limit of 5 ART cycles per person per lifetime	Maximum of 5 ART cycles per person per lifetime	Maximum limit of 5 ART cycles per person per lifetime		
Does plan cover other reproductive services including birth control and	Yes - birth control; no - voluntary	Yes	Yes	Yes		Yes		Yes	Yes	Yes		
Hearing Aid Benefit	Not covered	Not covered	Not covered	Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		Every two years plan pays for first $500 of expense and 20% coins. of next $1,500	Every two years plan pays for first $500 of expense and 20% coins. of next $1,500	Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		
Ambulance Service	No cost for emergency; 20% coinsurance after EB annual deductible for other non-emergency medically necessary transport	No copay	No cost for emergency; 20% coins. after annual deductible for other non-emergency medically necessary transport	None	20% after annual deductible	None		None	None	None		
Gym Membership Benefit	None	Yes; $150 gym membership reimbursement per household		None		$150 gym membership reimbursement per household		None	None	None		

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