



Town of Shrewsbury

MASSACHUSETTS 01545-5398

August 29, 2013

To: Insurance Advisory Committee (IAC)

From: Daniel J. Morgado

Re: Health Insurance Program (HIP) Proposal for FY 2015 & FY 2016

I send to you this date for your consideration a HIP proposal as outlined in this memo and attachments to become effective on July 1, 2014.

As you recall, our current agreement on the HIP will end on June 30, 2014.

It is important to review how expenditures for health insurance have grown over the years and how working together the fiscal impact on both the Town and employee/retiree has been mitigated and layoffs avoided:

FY 00	\$1,879,964	
FY 01	\$2,573,606	36.90%
FY 02	\$2,991,004	16.22%
FY 03	\$3,836,906	28.28%
FY 04	\$4,483,109	16.84%
FY 05	\$5,529,698	23.35%
FY 06	\$5,376,598	-2.77%
FY 07	\$5,684,151	5.72%
FY 08	\$6,734,763	18.48%
FY 09	\$6,282,138	-6.72%
FY 10	\$6,973,058	11.00%
FY 11	\$6,787,930	-2.65%
FY 12	\$7,569,126	11.51%
FY 13	\$7,523,301	-0.60%
FY 14 (est)	\$8,100,000	7.67%

Despite the best efforts of all concerned particularly employees and retirees, HIP costs continue to rise and such increases are unsustainable.

I am proposing that the HIP for FY 2015 and FY 2016 to take the following form:

1. Renew all senior plans as offered through the West Suburban Health Group (WSHG) with contribution changes for the Fallon Senior Plan and Tufts Medicare Preferred moving from 75%/25% to 70%/30%. This contribution change would take place on January 1, 2015.

2. Effective July 1, 2014, all active employees and non-Medicare eligible retirees are moved to the WSHG Benchmark plans. There will be no change in contribution rates.
3. The Harvard Pilgrim PPO and Tufts POS plans remain.
4. That this program remain in effect for a two year period commencing July 1, 2014 with no other changes to be made other than plan design changes requested by the respective carriers and changes in monthly premiums resulting from the FY 2015 and FY 2016 premium rating process. In the case of the Fallon dental plan design element, this may go away in FY 2015 or FY 2016.

Following this memo are a series of Exhibits that I will review in detail with you at our meeting on September 4, 2013, at 3:00 PM.

I know that I will get a fair hearing in this regard and thank you beforehand for that consideration.

Please advise me directly with any questions.

Cc Union/Association Presidents
Carol Cormier
Thomas Gregory
Carolyn Marcotte
Barbara Malone
Liam Hurley

Exhibit 1

Current Program

Plan	Type	Premium	Town Share	Percent	Employee/ Retiree Share	Percent	# of Participants	% of Plans	Town Share (Annual)	Employee/ Retiree Share (Annual)	Total	Town Share Budget	Employee/ Retiree Share Budget	Total
Harvard Pilgrim PPO	Family	\$3,886.00	\$1,943.00	50.00%	\$1,943.00	50.00%	0	0.00%	\$23,316.00	\$23,316.00	\$46,632.00	\$0.00	\$0.00	\$0.00
	Individual	\$1,750.00	\$875.00	50.00%	\$875.00	50.00%	6	0.73%	\$10,500.00	\$10,500.00	\$21,000.00	\$63,000.00	\$63,000.00	\$126,000.00
Tufts POS	Family	\$3,886.00	\$1,943.00	50.00%	\$1,943.00	50.00%	0	0.00%	\$23,316.00	\$23,316.00	\$46,632.00	\$0.00	\$0.00	\$0.00
	Individual	\$1,750.00	\$875.00	50.00%	\$875.00	50.00%	0	0.00%	\$10,500.00	\$10,500.00	\$21,000.00	\$0.00	\$0.00	\$0.00
Blue Choice Rate Saver EPO	Family	\$1,685.00	\$1,011.00	60.00%	\$674.00	40.00%	4	0.49%	\$12,132.00	\$8,088.00	\$20,220.00	\$48,528.00	\$32,352.00	\$80,880.00
	Individual	\$628.00	\$376.80	60.00%	\$251.20	40.00%	2	0.24%	\$4,521.60	\$3,014.40	\$7,536.00	\$9,043.20	\$6,028.80	\$15,072.00
Tufts Navigator Rate Saver EPO	Family	\$1,688.00	\$1,012.80	60.00%	\$675.20	40.00%	7	0.85%	\$12,153.60	\$8,102.40	\$20,256.00	\$85,075.20	\$56,716.80	\$141,792.00
	Individual	\$645.00	\$387.00	60.00%	\$258.00	40.00%	0	0.00%	\$4,644.00	\$3,096.00	\$7,740.00	\$0.00	\$0.00	\$0.00
HPHC Rate Saver EPO	Family	\$1,590.00	\$954.00	60.00%	\$636.00	40.00%	35	4.26%	\$11,448.00	\$7,632.00	\$19,080.00	\$400,680.00	\$267,120.00	\$667,800.00
	Individual	\$610.00	\$366.00	60.00%	\$244.00	40.00%	48	5.85%	\$4,392.00	\$2,928.00	\$7,320.00	\$210,816.00	\$140,544.00	\$351,360.00
Fallon Select Rate Saver EPO	Family	\$1,460.00	\$1,065.80	73.00%	\$394.20	27.00%	364	44.34%	\$12,789.60	\$4,730.40	\$17,520.00	\$4,655,414.40	\$1,721,865.60	\$6,377,280.00
	Individual	\$542.00	\$395.66	73.00%	\$146.34	27.00%	217	26.43%	\$4,747.92	\$1,756.08	\$6,504.00	\$1,030,298.64	\$381,069.36	\$1,411,368.00
Fallon Direct Rate Saver EPO	Family	\$1,357.00	\$1,058.46	78.00%	\$298.54	22.00%	88	10.72%	\$12,701.52	\$3,582.48	\$16,284.00	\$1,117,733.76	\$315,258.24	\$1,432,992.00
	Individual	\$505.00	\$393.90	78.00%	\$111.10	22.00%	50	6.09%	\$4,726.80	\$1,333.20	\$6,060.00	\$236,340.00	\$66,660.00	\$303,000.00
							821	100%	Fallon Makes Up		87.58%	\$7,856,929.20	\$3,050,614.80	\$10,907,544.00
									# of Plans		719	72.03%	27.97%	
Harvard Pilgrim Medicare Enhance	Retiree	\$378.00	\$189.00	50.00%	\$189.00	50.00%	170	46.45%	\$2,268.00	\$2,268.00	\$4,536.00	\$385,560.00	\$385,560.00	\$771,120.00
BC/BS Medex III	Retiree	\$424.00	\$212.00	50.00%	\$212.00	50.00%	6	1.64%	\$2,544.00	\$2,544.00	\$5,088.00	\$15,264.00	\$15,264.00	\$30,528.00
Tufts Medicare Plus	Retiree	\$332.00	\$166.00	50.00%	\$166.00	50.00%	27	7.38%	\$1,992.00	\$1,992.00	\$3,984.00	\$53,784.00	\$53,784.00	\$107,568.00
BC/BS Managed Blue for Seniors	Retiree	\$402.00	\$241.20	60.00%	\$160.80	40.00%	4	1.09%	\$2,894.40	\$1,929.60	\$4,824.00	\$11,577.60	\$7,718.40	\$19,296.00
Fallon Senior	Retiree	\$279.00	\$209.25	75.00%	\$69.75	25.00%	153	41.80%	\$2,511.00	\$837.00	\$3,348.00	\$384,183.00	\$128,061.00	\$512,244.00
Tufts Medicare Preferred	Retiree	\$240.00	\$180.00	75.00%	\$60.00	25.00%	6	1.64%	\$2,160.00	\$720.00	\$2,880.00	\$12,960.00	\$4,320.00	\$17,280.00
Enrollments shown above include SELCO							366					\$863,328.60	\$594,707.40	\$1,458,036.00
												59.21%	40.79%	
							1,187					\$8,720,257.80	\$3,645,322.20	\$12,365,580.00
												70.52%	29.48%	

**TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2013-2014**

JUNE PAYROLL CHANGES FOR JULY 1, 2011 OPEN-ENROLLMENT

% PAID	PLAN TYPE	TOTAL MONTHLY	TOWN MONTHLY	TOWN 26 P/R BI-WEEKLY*	TOWN 21 P/R BI-WEEKLY**	TOWN * WEEKLY	EMPLOYEE MONTHLY	EMP. 26 P/R BIWEEKLY*	EMP. 21P/R BI-WEEKLY**	EMPLOYEE WEEKLY*	COBRA
INDEMNITY PLANS											
Harvard Pilgrim PPO											
50/50	FAMILY	\$3,886.00	\$1,943.00	\$896.77	\$1,110.29	\$448.38	\$1,943.00	\$896.77	\$1,110.29	\$448.38	\$3,963.72
50/50	FAMILY (SS)	\$3,886.00	\$1,943.00	\$896.77	\$1,110.29	\$448.38	\$1,943.00	\$896.77	\$1,110.29	\$448.38	
50/50	INDIVIDUAL	\$1,750.00	\$875.00	\$403.85	\$500.00	\$201.92	\$875.00	\$403.85	\$500.00	\$201.92	\$1,785.00
50/50	INDIVIDUAL (SS)	\$1,750.00	\$875.00	\$403.85	\$500.00	\$201.92	\$875.00	\$403.85	\$500.00	\$201.92	
Tufts POS											
50/50	FAMILY	\$3,886.00	\$1,943.00	\$896.77	\$1,110.29	\$448.38	\$1,943.00	\$896.77	\$1,110.29	\$448.38	\$3,963.72
50/50	FAMILY (SS)	\$3,886.00	\$1,943.00	\$896.77	\$1,110.29	\$448.38	\$1,943.00	\$896.77	\$1,110.29	\$448.38	
50/50	INDIVIDUAL	\$1,750.00	\$875.00	\$403.85	\$500.00	\$201.92	\$875.00	\$403.85	\$500.00	\$201.92	\$1,785.00
50/50	INDIVIDUAL (SS)	\$1,750.00	\$875.00	\$403.85	\$500.00	\$201.92	\$875.00	\$403.85	\$500.00	\$201.92	
RATE SAVER HMO PLANS											
BLUE OPTIONS RATE SAVER EPO											
60/40	FAMILY	\$1,685.00	\$1,011.00	\$466.62	\$577.71	\$233.31	\$674.00	\$311.08	\$385.14	\$155.54	\$1,718.70
50/50	FAMILY (SS)	\$1,685.00	\$842.50	\$388.85	\$481.43	\$194.42	\$842.50	\$388.85	\$481.43	\$194.42	
60/40	INDIVIDUAL	\$628.00	\$376.80	\$173.91	\$215.31	\$86.95	\$251.20	\$115.94	\$143.54	\$57.97	\$640.56
50/50	INDIVIDUAL (SS)	\$628.00	\$314.00	\$144.92	\$179.43	\$72.46	\$314.00	\$144.92	\$179.43	\$72.46	
TUFTS NAVIGATOR RATE SAVER EPO											
60/40	FAMILY	\$1,688.00	\$1,012.80	\$467.45	\$578.74	\$233.72	\$675.20	\$311.63	\$385.83	\$155.82	\$1,721.76
50/50	FAMILY (SS)	\$1,688.00	\$844.00	\$389.54	\$482.29	\$194.77	\$844.00	\$389.54	\$482.29	\$194.77	
60/40	INDIVIDUAL	\$645.00	\$387.00	\$178.62	\$221.14	\$89.31	\$258.00	\$119.08	\$147.43	\$59.54	\$657.90
50/50	INDIVIDUAL (SS)	\$645.00	\$322.50	\$148.85	\$184.29	\$74.42	\$322.50	\$148.85	\$184.29	\$74.42	
HPHC RATE SAVER EPO											
60/40	FAMILY	\$1,590.00	\$954.00	\$440.31	\$545.14	\$220.15	\$636.00	\$293.54	\$363.43	\$146.77	\$1,621.80
50/50	FAMILY (SS)	\$1,590.00	\$795.00	\$366.92	\$454.29	\$183.46	\$795.00	\$366.92	\$454.29	\$183.46	
60/40	INDIVIDUAL	\$610.00	\$366.00	\$168.92	\$209.14	\$84.46	\$244.00	\$112.62	\$139.43	\$56.31	\$622.20
50/50	INDIVIDUAL (SS)	\$610.00	\$305.00	\$140.77	\$174.29	\$70.38	\$305.00	\$140.77	\$174.29	\$70.38	
FALLON SELECT RATE SAVER EPO											
73/27	FAMILY	\$1,460.00	\$1,065.80	\$491.91	\$609.03	\$245.95	\$394.20	\$181.94	\$225.26	\$90.97	\$1,489.20
50/50	FAMILY (SS)	\$1,460.00	\$730.00	\$336.92	\$417.14	\$168.46	\$730.00	\$336.92	\$417.14	\$168.46	
73/27	INDIVIDUAL	\$542.00	\$395.66	\$182.61	\$226.09	\$91.31	\$146.34	\$67.54	\$83.62	\$33.77	\$552.84
50/50	INDIVIDUAL (SS)	\$542.00	\$271.00	\$125.08	\$154.86	\$62.54	\$271.00	\$125.08	\$154.86	\$62.54	
FALLON DIRECT RATE SAVER EPO											
78/22	FAMILY	\$1,357.00	\$1,058.46	\$488.52	\$604.83	\$244.26	\$298.54	\$137.79	\$170.59	\$68.89	\$1,384.14
50/50	FAMILY (SS)	\$1,357.00	\$678.50	\$313.15	\$387.71	\$156.58	\$678.50	\$313.15	\$387.71	\$156.58	
78/22	INDIVIDUAL	\$505.00	\$393.90	\$181.80	\$225.09	\$90.90	\$111.10	\$51.28	\$63.49	\$25.64	\$515.10
50/50	INDIVIDUAL (SS)	\$505.00	\$252.50	\$116.54	\$144.29	\$58.27	\$252.50	\$116.54	\$144.29	\$58.27	

(SS) REPRESENTS SURVIVING SPOUSE

* PLEASE NOTE BI-WEEKLY & WEEKLY DEDUCTIONS ARE BASED ON 26 & 52 WEEK PAYROLLS RESPECTIVELY.
**SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)

TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP SENIOR PLANS
RATES AS OF January 1, 2013

% PAID		TOTAL	TOWN	RETIREE
Town/Retiree		MONTHLY	MONTHLY	MONTHLY
MEDICARE SUPPLEMENT PLANS				
FREEDOM OF CHOICE				
HARVARD PILGRIM - MEDICARE ENHANCE				
50/50	SUBSCRIBER	\$378.00	\$189.00	\$189.00
50/50	SURVIVING SPOUSE	\$378.00	\$189.00	\$189.00
BC/BS - MEDEX III (WITH OBRA)				
50/50	SUBSCRIBER	\$424.00	\$212.00	\$212.00
50/50	SURVIVING SPOUSE	\$424.00	\$212.00	\$212.00
TUFTS - MEDICARE PLUS				
50/50	SUBSCRIBER	\$332.00	\$166.00	\$166.00
50/50	SURVIVING SPOUSE	\$332.00	\$166.00	\$166.00
HMO MEDI-WRAP PLANS				
BC/BS - MANAGED BLUE FOR SENIORS				
60/40	SUBSCRIBER	\$402.00	\$241.20	\$160.80
50/50	SURVIVING SPOUSE	\$402.00	\$201.00	\$201.00
MEDICARE ADVANTAGE HMO PLANS				
FALLON - SENIOR PLAN				
75/25	SUBSCRIBER	\$279.00	\$209.25	\$69.75
50/50	SURVIVING SPOUSE	\$279.00	\$139.50	\$139.50
TUFTS - MEDICARE PREFERRED				
75/25	SUBSCRIBER	\$240.00	\$180.00	\$60.00
50/50	SURVIVING SPOUSE	\$240.00	\$120.00	\$120.00

Exhibit 2

WSHG

Adopt Benchmark Plans

Changes in Contribution Rates

Fallon Senior & Tufts Medicare Preferred

Plan	Type	Premium	Town Share	Percent	Employee/ Retiree Share	Percent	# of Participants	% of Plans	Town Share (Annual)	Employee/ Retiree Share (Annual)	Total	Town Share Budget	Employee/ Retiree Share Budget	Total
Harvard Pilgrim PPO	Family	\$3,886.00	\$1,943.00	50.00%	\$1,943.00	50.00%	0	0.00%	\$23,316.00	\$23,316.00	\$46,632.00	\$0.00	\$0.00	\$0.00
	Individual	\$1,750.00	\$875.00	50.00%	\$875.00	50.00%	6	0.73%	\$10,500.00	\$10,500.00	\$21,000.00	\$63,000.00	\$63,000.00	\$126,000.00
Tufts POS	Family	\$3,886.00	\$1,943.00	50.00%	\$1,943.00	50.00%	0	0.00%	\$23,316.00	\$23,316.00	\$46,632.00	\$0.00	\$0.00	\$0.00
	Individual	\$1,750.00	\$875.00	50.00%	\$875.00	50.00%	0	0.00%	\$10,500.00	\$10,500.00	\$21,000.00	\$0.00	\$0.00	\$0.00
Blue Choice Benchmark	Family	\$1,625.00	\$975.00	60.00%	\$650.00	40.00%	4	0.49%	\$11,700.00	\$7,800.00	\$19,500.00	\$46,800.00	\$31,200.00	\$78,000.00
	Individual	\$606.00	\$363.60	60.00%	\$242.40	40.00%	2	0.24%	\$4,363.20	\$2,908.80	\$7,272.00	\$8,726.40	\$5,817.60	\$14,544.00
Tufts Navigator Benchmark	Family	\$1,629.00	\$977.40	60.00%	\$651.60	40.00%	7	0.85%	\$11,728.80	\$7,819.20	\$19,548.00	\$82,101.60	\$54,734.40	\$136,836.00
	Individual	\$622.00	\$373.20	60.00%	\$248.80	40.00%	0	0.00%	\$4,478.40	\$2,985.60	\$7,464.00	\$0.00	\$0.00	\$0.00
HPHC Rate EPO Benchmark	Family	\$1,534.00	\$920.40	60.00%	\$613.60	40.00%	35	4.26%	\$11,044.80	\$7,363.20	\$18,408.00	\$386,568.00	\$257,712.00	\$644,280.00
	Individual	\$588.00	\$352.80	60.00%	\$235.20	40.00%	48	5.85%	\$4,233.60	\$2,822.40	\$7,056.00	\$203,212.80	\$135,475.20	\$338,688.00
Fallon Select Benchmark	Family	\$1,410.00	\$1,029.30	73.00%	\$380.70	27.00%	364	44.34%	\$12,351.60	\$4,568.40	\$16,920.00	\$4,495,982.40	\$1,662,897.60	\$6,158,880.00
	Individual	\$524.00	\$382.52	73.00%	\$141.48	27.00%	217	26.43%	\$4,590.24	\$1,697.76	\$6,288.00	\$996,082.08	\$368,413.92	\$1,364,496.00
Fallon Direct Benchmark	Family	\$1,310.00	\$1,021.80	78.00%	\$288.20	22.00%	88	10.72%	\$12,261.60	\$3,458.40	\$15,720.00	\$1,079,020.80	\$304,339.20	\$1,383,360.00
	Individual	\$487.00	\$379.86	78.00%	\$107.14	22.00%	50	6.09%	\$4,558.32	\$1,285.68	\$5,844.00	\$227,916.00	\$64,284.00	\$292,200.00
							821	100%	Fallon Makes Up # of Plans		87.58% 719	\$7,589,410.08	\$2,947,873.92	\$10,537,284.00
												72.02%	27.98%	
Harvard Pilgrim Medicare Enhance	Retiree	\$378.00	\$189.00	50.00%	\$189.00	50.00%	170	46.45%	\$2,268.00	\$2,268.00	\$4,536.00	\$385,560.00	\$385,560.00	\$771,120.00
BC/BS Medex III	Retiree	\$424.00	\$212.00	50.00%	\$212.00	50.00%	6	1.64%	\$2,544.00	\$2,544.00	\$5,088.00	\$15,264.00	\$15,264.00	\$30,528.00
Tufts Medicare Plus	Retiree	\$332.00	\$166.00	50.00%	\$166.00	50.00%	27	7.38%	\$1,992.00	\$1,992.00	\$3,984.00	\$53,784.00	\$53,784.00	\$107,568.00
BC/BS Managed Blue for Seniors	Retiree	\$402.00	\$241.20	60.00%	\$160.80	40.00%	4	1.09%	\$2,894.40	\$1,929.60	\$4,824.00	\$11,577.60	\$7,718.40	\$19,296.00
Fallon Senior	Retiree	\$279.00	\$195.30	70.00%	\$83.70	30.00%	153	41.80%	\$2,343.60	\$1,004.40	\$3,348.00	\$358,570.80	\$153,673.20	\$512,244.00
Tufts Medicare Preferred	Retiree	\$240.00	\$168.00	70.00%	\$72.00	30.00%	6	1.64%	\$2,016.00	\$864.00	\$2,880.00	\$12,096.00	\$5,184.00	\$17,280.00
Enrollments shown above include SELCO							366					\$836,852.40	\$621,183.60	\$1,458,036.00
												57.40%	42.60%	
							1,187					\$8,426,262.48	\$3,569,057.52	\$11,995,320.00
												70.25%	29.75%	

West Suburban Health Group
POLICY PERIOD 7/1/13 - 6/30/14

APPROVED SCENARIO **FY14 HEALTH INSURANCE FUNDING SCENARIO**

\$5.9 million subsidy to Rate Savers only

Health Plan	12/12 Enrollments		Projected FY14 Rates		FY14 MONTHLY	FY14 ANNUAL	%
	Individual	Family	Individual	Family	FUNDING	FUNDING	
Harvard Pilgrim EPO	101	85	\$ 798.00	\$ 2,085.00	\$ 257,823	\$ 3,093,876	6.2%
HPHC Rate Saver EPO	1669	2307	\$ 610.00	\$ 1,590.00	\$ 4,686,220	\$ 56,234,640	4.0%
HPHC EPO Benchmark	0	1	\$ 588.00	\$ 1,534.00	\$ 1,534	\$ 18,408	4.0%
Network Blue EPO	80	23	\$ 978.00	\$ 2,623.00	\$ 138,569	\$ 1,662,828	16.5%
Blue Choice Rate Saver	346	423	\$ 628.00	\$ 1,685.00	\$ 930,043	\$ 11,160,516	4.0%
Blue Choice Benchmark	6	6	\$ 606.00	\$ 1,625.00	\$ 13,386	\$ 160,632	4.0%
Tufts EPO	52	29	\$ 985.00	\$ 2,582.00	\$ 126,098	\$ 1,513,176	19.1%
Tufts Navigator Rate Saver	550	771	\$ 645.00	\$ 1,688.00	\$ 1,656,198	\$ 19,874,376	4.0%
Tufts Navigator Benchmark	0	0	\$ 622.00	\$ 1,629.00	\$ -	\$ -	rate incs is 4.0%
Fallon Selectcare HMO	6	-	\$ 660.00	\$ 1,778.00	\$ 3,960	\$ 47,520	7.7%
Fallon Select Rate Saver	371	533	\$ 542.00	\$ 1,460.00	\$ 979,262	\$ 11,751,144	4.0%
Fallon Select Benchmark	0	0	\$ 524.00	\$ 1,410.00	\$ -	\$ -	rate incs is 4.0%
Fallon Directcare HMO	-	1	\$ 612.00	\$ 1,653.00	\$ 1,653	\$ 19,836	7.7%
Fallon Direct Rate Saver	109	118	\$ 505.00	\$ 1,357.00	\$ 215,171	\$ 2,582,052	4.0%
Fallon Direct Benchmark	0	0	\$ 487.00	\$ 1,310.00	\$ -	\$ -	rate incs is 4.0%
Harvard Pilgrim PPO	64	11	\$ 1,750.00	\$ 3,886.00	\$ 154,746	\$ 1,856,952	12.0%
Tufts POS	3	1	\$ 1,750.00	\$ 3,886.00	\$ 9,136	\$ 109,632	12.0%
TOTALS:	3,357	4,309			\$ 9,173,799	\$ 110,085,588	4.56%

Amount of fund balance at risk based on Scenario B-1: \$ 5,903,918

Exhibit 3

Financial Impact of HIP Proposal

			Current Program	WSHG Benchmark Plans/Contribution Shift Fallon Senior - Tufts Medicare Preferred Only	Change From Current	Percent	
Employer Share (Active)			\$7,856,929.20	\$7,589,410.08	(\$267,519.12)	-3.40%	
Employer Share (Medicare)			\$863,328.60	\$836,852.40	(\$26,476.20)	-3.07%	
		Total	\$8,720,257.80	\$8,426,262.48	(\$293,995.32)	-3.37%	
Employee/Retiree Share (Active)			\$3,050,614.80	\$2,947,873.92	(\$102,740.88)	-3.37%	
Retiree Share (Medicare)			\$594,707.40	\$621,183.60	\$26,476.20	4.45%	
		Total	\$3,645,322.20	\$3,569,057.52	(\$76,264.68)	-2.09%	
Total Cost (Active)			\$10,907,544.00	\$10,537,284.00	(\$370,260.00)	-3.39%	
Total Cost (Medicare)			\$1,458,036.00	\$1,458,036.00	\$0.00	0.00%	
		Total	\$12,365,580.00	\$11,995,320.00	(\$370,260.00)	-2.99%	
Blue Choice	F	Tn	\$1,011.00	\$975.00	(\$36.00)	-3.56%	(\$432.00)
	4	Em	\$674.00	\$650.00	(\$24.00)	-3.56%	(\$288.00)
			\$1,685.00	\$1,625.00	(\$60.00)	-3.56%	
	I	Tn	\$376.80	\$363.60	(\$13.20)	-3.50%	(\$158.40)
	2	Em	\$251.20	\$242.40	(\$8.80)	-3.50%	(\$105.60)
			\$628.00	\$606.00	(\$22.00)	-3.50%	
Tufts Navigator	F	Tn	\$1,012.80	\$977.40	(\$35.40)	-3.50%	(\$424.80)
	7	Em	\$675.20	\$651.60	(\$23.60)	-3.50%	(\$283.20)
			\$1,688.00	\$1,629.00	(\$59.00)	-3.50%	
	I	Tn	\$387.00	\$373.20	(\$13.80)	-3.57%	(\$165.60)
	0	Em	\$258.00	\$248.80	(\$9.20)	-3.57%	(\$110.40)
			\$645.00	\$622.00	(\$23.00)	-3.57%	
HPHC	F	Tn	\$954.00	\$920.40	(\$33.60)	-3.52%	(\$403.20)
	35	Em	\$636.00	\$613.60	(\$22.40)	-3.52%	(\$268.80)
			\$1,590.00	\$1,534.00	(\$56.00)	-3.52%	
	I	Tn	\$366.00	\$352.80	(\$13.20)	-3.61%	(\$158.40)
	48	Em	\$244.00	\$235.20	(\$8.80)	-3.61%	(\$105.60)
			\$610.00	\$588.00	(\$22.00)	-3.61%	
Employer Share - Fallon Select	F	Tn	\$1,065.80	\$1,029.30	(\$36.50)	-3.42%	(\$438.00)
	364	Em	\$394.20	\$380.70	(\$13.50)	-3.42%	(\$162.00)
			\$1,460.00	\$1,410.00	(\$50.00)	-3.42%	
	I	Tn	\$395.66	\$382.52	(\$13.14)	-3.32%	(\$157.68)
	217	Em	\$146.34	\$141.48	(\$4.86)	-3.32%	(\$58.32)
			\$542.00	\$524.00	(\$18.00)	-3.32%	
Employer Share - Fallon Direct	F	Tn	\$1,058.46	\$1,021.80	(\$36.66)	-3.46%	(\$439.92)
	88	Em	\$298.54	\$288.20	(\$10.34)	-3.46%	(\$124.08)
			\$1,357.00	\$1,310.00	(\$47.00)	-3.46%	
	I	Tn	\$393.90	\$379.86	(\$14.04)	-3.56%	(\$168.48)
	50	Em	\$111.10	\$107.14	(\$3.96)	-3.56%	(\$47.52)
			\$505.00	\$487.00	(\$18.00)	-3.56%	

		Current Program	WSHG Benchmark Plans/Contribution Shift Fallon Senior - Tufts Medicare Preferred Only	Change From Current	Percent	
Fallon Senior	I Tn	\$209.25	\$195.30	(\$13.95)	-6.67%	(\$167.40)
	153 Rt	\$69.75	\$83.70	\$13.95	20.00%	\$167.40
		\$279.00	\$279.00	\$0.00	0.00%	
Tufts Medicare Preferred	I Tn	\$180.00	\$168.00	(\$12.00)	-6.67%	(\$144.00)
	6 Rt	\$60.00	\$72.00	\$12.00	20.00%	\$144.00
		\$240.00	\$240.00	\$0.00	0.00%	

Exhibit 4

Plan Design Comparisons

BENEFIT	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN				FALLON COMMUNITY HEALTH PLAN SelectCare (SC) & DirectCare (DC)	
	PPO		HMO RATE SAVER	CHOICENET BENCHMARK PLAN	NETWORK BLUE NE OPTIONS TIERED NETWORK HMO RATE SAVER	BENCHMARK PLAN	EPO RATE SAVER (Navigator)	BENCHMARK PLAN	POS		EPO RATE SAVER	BENCHMARK PLAN
	IN-NETWORK	OUT-OF-NETWORK							IN-NETWORK	OUT-OF-NETWORK		
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None	None	None	None	None	None	None	None	None
Deductible - (Benchmark Plans only) applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - See plan document for full details	None	IND \$100 / FAM \$200 per calendar year	None	IND \$250/ FAM \$750	None	IND \$250/ FAM \$750	None	IND \$250/ FAM \$750	None	None	None	IND \$250/ FAM \$750
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for remainder of plan year. NOTE: Prescription co-pays do not count towards the OOP maximum.	None	\$1,600 per member \$3,200 per family per calendar year - see plan for details	\$2,000 Individual \$4,000 Family	\$2,000 Individual \$4,000 Family	\$2,000 Individual \$4,000 Family	\$2,000 Individual \$4,000 Family	None	\$2,000 Individual \$4,000 Family	\$1,500 per member per year not to exceed \$3,000 per family per year (includes deductible)	\$1,500 per member per year not to exceed \$3,000 per family per year (includes deductible)	As noted	\$2,000 Individual \$4,000 Family
Family Covered	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Any PCP in network	No selection required	Member must select	Member must select	Member must select	Member must select	No selection required	No selection required	Any PCP in network	No requirement	Member must select	Member must select
Specialist Referrals	Any HPHC Specialist	Any licensed specialist	PCP must refer	PCP must refer	PCP must refer	PCP must refer	No referral required	No referral required	PCP refers within the plan	Any licensed specialist	PCP must refer	PCP must refer
Providers of Service	HARVARD PILGRIM providers - Members also have access to a wide range of participating providers through the Private Health Care Systems network while outside of MA, NH and ME	Any licensed provider; any hospital	HARVARD PILGRIM providers except in emergencies	HARVARD PILGRIM providers except in emergencies	HMO BLUE providers in all 6 New England states except in emergencies	HMO BLUE providers in all 6 New England states except in emergencies	TUFTS HEALTH PLAN providers except in emergencies	TUFTS HEALTH PLAN providers except in emergencies	TUFTS HEALTH PLAN providers except in emergencies	Any licensed provider; any hospital	**SELECT CARE - An expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 17,000 providers and 50 hospitals. *DIRECTCARE - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.	**SELECT CARE - An expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 17,000 providers and 50 hospitals. *DIRECTCARE - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions

BENEFIT	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN				FALLON COMMUNITY HEALTH PLAN SelectCare (SC) & DirectCare (DC)	
	PPO		HMO RATE SAVER	CHOICENET BENCHMARK PLAN	NETWORK BLUE NE OPTIONS TIERED NETWORK HMO RATE SAVER	BENCHMARK PLAN	EPO RATE SAVER (Navigator)	BENCHMARK PLAN	POS		EPO RATE SAVER	BENCHMARK PLAN
	IN-NETWORK	OUT-OF-NETWORK							IN-NETWORK	OUT-OF-NETWORK		
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
INPATIENT												
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Nothing	20% coinsurance after deductible	\$250 copay	Deductible applies then: Tier 1 & Tier 2 :\$300 per/Admit Tier 3 : \$700 per/Admit NOTE- Mental Health/Substance Abuse copay \$200	Enhanced: \$250 copay Standard: \$500 copay Basic: \$500 copay Out-of-state copay: \$250 NOTE-Mental Health/Substance Abuse copay \$250	Deductible , then \$300/\$700 copay	Semi-private room & board & ancillary services Tier 1: \$150 copay Tier 2: \$250 copay NOTE-Mental Health/Substance Abuse copay \$150	Semi-private room & board & ancillary services Tier 1: \$300 copay, then deductible applies Tier 2: \$700 copay, then deductible applies NOTE- Mental Health/Substance Abuse copay \$200	Nothing	20% coinsurance after deductible	\$250 copay per admission (\$1,000 out-of-pocket maximum)	\$300 copay per admission, then deductible
Physician Services	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing (Hospital copay applies)	Nothing	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing, after deductible
Skilled Nursing Facility	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year	\$250 copayment for each admission, up to 100 days per year	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Nothing up to 100 days per year	Deductible, then covered in full	Covered in full up to 100 days per year	Covered in Full after Deductible, up to 100 days per year	Covered in full up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year	\$250 copayment for each admission, up to 100 days per year	\$300 copay per admission, then deductible Max of 100 days per year.
Newborn Well Baby Care (Inpatient)	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing
OUTPATIENT												
Emergency Room Visits for Emergency or Accident Care	\$40 copay, waived if admitted	\$40 copay, waived if admitted	\$75 copay (Inpatient copay applies if admitted) in Service Area	Deductible applies, then \$100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	\$75 copay (Inpatient copay applies if admitted)	Deductible applies, then \$100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	\$75 copay (Inpatient copay applies if admitted)	\$100 copay, then deductible applies (Inpatient copay applies if admitted)	\$25 copay, waived if admitted	\$25 copay, waived if admitted	\$75 copay (Inpatient copay applies if admitted)	\$100 copay, then deductible applies (waived if admitted, then Inpatient copay applies)
Emergency Care in Doctor's Office	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Outpatient Surgery in a Day Surgery facility or Hospital	Nothing	20% coinsurance after deductible	\$125 copay per outpatient surgery	Deductible applies, then \$150 copay per visit	Enhanced: \$150 copay Standard: \$250 copay Basic: \$250 copay Out-of-State copay \$150	Deductible, then \$150 copay	\$125 copay per outpatient surgery	\$150 copay per outpatient surgery, then deductible	Nothing	20% coinsurance after deductible	\$125 copay per outpatient surgery	\$150 copay per outpatient surgery, then deductible
CT, MRI and Pet Scans	Nothing	20% coinsurance after deductible	Nothing	Deductible applies, then \$100 Copay per procedure	General Hospitals: Enhanced: \$75 copay Standard: \$150 copay Basic: \$150 Other Providers: \$75 copay	Deductible, then \$100 copay (scheduled outpatient)	\$75 copay	Deductible, then \$100 copay	Nothing	20% coinsurance after deductible	Nothing	\$100 copay, then deductible
Hemodialysis	Nothing	20% coinsurance after deductible	Nothing	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient Services	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full
Physical Therapy	\$5 copay per visit	20% coinsurance after deductible	\$20 copay (short-term); up to 90 consecutive days per condition	Copay: \$20 per visit - Limited to 30 visits per PlanYear	\$45 copay; up to 60 visits per calendar year	\$20 copay; up to 60 visits per calendar year	Speech and short-term PT/OT \$20 copay per visit; 30 visits per calendar year	Speech and short-term PT/OT \$20 copay per visit; 30 visits per plan year	\$5 office copay, 30 visits per year	20% coinsurance after deductible	\$20 copay; up to 20 visits per calendar year	\$20 copay, PT / OT Max limit up to 60 visits per calendar year

BENEFIT	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN				FALLON COMMUNITY HEALTH PLAN SelectCare (SC) & DirectCare (DC)	
	PPO		HMO RATE SAVER	CHOICENET BENCHMARK PLAN	NETWORK BLUE NE OPTIONS TIERED NETWORK HMO RATE SAVER	BENCHMARK PLAN	EPO RATE SAVER (Navigator)	BENCHMARK PLAN	POS		EPO RATE SAVER	BENCHMARK PLAN
	IN-NETWORK	OUT-OF-NETWORK							IN-NETWORK	OUT-OF-NETWORK		
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Office Visits Primary Care Physician	\$5 copay per visit	Not covered	\$20 copay per visit	\$20 copay per visit	Enhanced: \$15 copay Standard: \$25 copay Basic: \$45 copay Out-of-state copay	\$20 copay	\$20 copay per visit	\$20 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$20 copay per visit	\$20 copay per visit
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care (Mental Health copays excluded from OOP max)	\$5 copay per visit	20% coinsurance after deductible	\$20 copay per visit	\$20 copay per visit	Enhanced: \$15 copay Standard: \$25 copay Basic: \$45 copay Out-of-state copay: \$15 NOTE: Mental Health Care copay \$15	\$20 per visit	\$20 copay per visit	\$20 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$20 copay per visit	\$20 copay per visit
Office Visits Specialist	\$5 copay per visit	20% coinsurance after deductible	\$35 copay per visit	Tier 1 - \$25 copay per visit Tier 2 - \$35 copay per visit Tier 3 - \$45 copay per visit	\$45 copay per visit	\$35 copay per visit	\$35 copay per visit	\$35 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$35 copay per visit	\$35 copay per visit
OB/GYN	\$5 copay per visit	20% coinsurance after deductible	\$20 copay per visit	\$20 copay per visit	\$45 copay per visit	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$20 copay per visit	\$20 copay per visit
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full
Routine Vision Exam	\$5 copay per visit; one visit per calendar year. \$0 copay for children under 5 years of age Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers	\$20 copay per visit; one visit per calendar year. \$0 copay for children under 5 years of age	\$20 copay per visit; one exam every 2 plan years \$0 copay for children under 5 years of age	\$0 copay; one visit every 24 months	\$0 copay; one visit every 12 months	\$20 copay per visit; one visit per calendar year Eyewear discounts available at participating providers	\$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	\$5 copay Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers	\$0 copay per visit; one visit every 12 months	\$0 copay per visit; one visit every 12 months
Pre-Admission Testing	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full
Maternity Care visits	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	Prenatal:\$20 first visit only	\$20 copay per visit with a maximum of 10 visits for pre and post natal care, then covered in full.	\$20 copay per visit with a maximum of 10 visits for pre and post natal care, then covered in full.	\$5 copay per visit with max of 10 visits for pre and post-natal care, then covered in full	20% coinsurance after deductible	Prenatal: \$20 copay first visit only; Post natal: \$20 copay per visit	Prenatal: \$20 copay first visit only; Post // \$20 copay per visit after deductible
Dental Services	Children under age 14 - Covered in full for preventative care. All members - \$5 copay for extraction of impacted teeth and initial emergency treatment.	Children under age 14 - 20% coinsurance after deductible for preventative care. All members - 20% coinsurance after deductible for extraction of impacted teeth and initial emergency treatment.	Children under age 12 - Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	Preventative dental for children up to age 13 - Tier 1 Copayment per visit up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	No coverage	Children under age 12: Preventative dental up to two exams per cal. yr., incl. Cleaning, fluoride treatment and x-rays. All members: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed.	Children under age 12; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist.	Children under age 12; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist.	Not covered. Exceptions: All members - ER services following injury; Extraction of teeth	Not covered. Exceptions: All members - ER services following injury; Extraction of teeth	Family dental coverage: \$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.	Family dental coverage: \$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.

BENEFIT	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN				FALLON COMMUNITY HEALTH PLAN SelectCare (SC) & DirectCare (DC)		
	PPO		HMO RATE SAVER	CHOICENET BENCHMARK PLAN	NETWORK BLUE NE OPTIONS TIERED NETWORK HMO RATE SAVER	BENCHMARK PLAN	EPO RATE SAVER (Navigator)	BENCHMARK PLAN	POS		EPO RATE SAVER	BENCHMARK PLAN	
	IN-NETWORK	OUT-OF-NETWORK							IN-NETWORK	OUT-OF-NETWORK			
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	
OTHER FEATURES													
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	20% coinsurance after deductible	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Not covered	Not covered	Nothing when medically necessary	Nothing when medically necessary
Home Health Care	Nothing	20% coinsurance after deductible	Nothing	Member cost sharing depends on types of services provided and tier placement of provider rendering services, as listed in the Schedule of Benefits. For example, for services provided by a physician, see "physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	
Hospice Care	Nothing	20% coinsurance after deductible	Nothing	Same as Home Health Care	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	
Durable Medical Equipment	20% coinsurance	20% coinsurance, up to out-of-pocket max of \$1,000 per year, max benefit of \$5,000 per year	20% of HPHC cost	Deductible, then covered in full	Nothing up to \$750 per calendar year Prosthetics covered in full	Deductible, then 20% coinsurance Deductible, then 20% coinsurance	80% Covered	Deductible, then covered in full	80% Covered	80% Covered	Nothing 20% coinsurance for prosthetic limbs which replace, in whole or in part, an arm or leg.	Deductible, then covered in full 20% coinsurance after the deductible for prosthetic limbs which replace, in whole or in part, an arm or leg.	
Ambulance	Nothing, when medically necessary	Nothing, when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Deductible then covered in full	Nothing when medically necessary	Deductible then covered in full	Nothing, when medically necessary	20% coinsurance after deductible, when medically necessary	Nothing when medically necessary	Nothing when medically necessary	
Radiation Therapy	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	
Chemotherapy	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	
Chiropractor Visits (copays excluded from OOP max)	\$5 copay per visit, up to \$500 per calendar year	20% coinsurance after deductible	12 visit maximum per calendar year	\$20 copay, 20 visits per plan year	\$45 copay per visit, 12 visits maximum per calendar year	\$20 copay per visit, 12 visits maximum per calendar year	\$20 copay per visit; up to 12 visits per calendar year	\$20 copay per visit; up to 12 visits per calendar year	\$5 copay per visit, up to 12 visits per calendar year	20% coinsurance after deductible, up to 12 visits per calendar year	\$20 copay per visit; up to 12 visits per calendar year not to exceed \$500 per calendar year.	\$20 copay per visit; up to 12 visits per calendar year not to exceed \$500 per calendar year.	
Prescription Drugs (Inpatient drugs paid in)	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay up to a 30 day supply MedImpact Mail Order: Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$75 copay up to a 90 day supply	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay up to a 30 day supply No mail order coverage except through MedImpact Mail Order	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$45.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$90.00 copay	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail Pharmacy: Tier 1: \$15.00 copay Tier 2: \$30.00 copay Tier 3: \$50.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$30.00 copay Tier 2: \$60.00 copay Tier 3: \$100.00 copay	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$45.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$90.00 copay	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay up to a 30 day supply Mail Order: Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$50 copay up to a 90 day supply	No coverage except at PCS participating pharmacies No mail order coverage except through PCS	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$45.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$90.00 copay	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	

	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN				FALLON COMMUNITY HEALTH PLAN SelectCare (SC) & DirectCare (DC)	
	PPO		HMO RATE SAVER	CHOICENET BENCHMARK PLAN	NETWORK BLUE NE OPTIONS TIERED NETWORK HMO RATE SAVER	BENCHMARK PLAN	EPO RATE SAVER (Navigator)	BENCHMARK PLAN	POS		EPO RATE SAVER	BENCHMARK PLAN
	IN-NETWORK	OUT-OF-NETWORK							IN-NETWORK	OUT-OF-NETWORK		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Fitness Benefit	Reimbursement	Reimbursement	Reimbursement	Reimbursement	Reimbursement	Reimbursement	Reimbursement	Reimbursement	Reimbursement	Reimbursement	Reimbursement	Reimbursement
	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.</p> <p>Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®</p>	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.</p> <p>Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®</p>	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.</p> <p>Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®</p>	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.</p> <p>Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®</p>	<p>Up to \$300 reimbursement toward membership or exercise classes at a health club. See plan materials for details.</p> <p>Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to \$150 per calendar year toward your program fees.</p>	<p>Up to \$300 reimbursement toward membership or exercise classes at a health club. See plan materials for details.</p> <p>Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to \$150 per calendar year toward your program fees.</p>	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. See plan materials for details.</p>	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club per plan year. See plan materials for details.</p>	<p>Fitness reimbursement up to \$150 per subscriber at a fitness facility per calendar year. Must be an active member of the THP and fitness facility for 4 months.</p> <p>Discount at Weight Watchers®</p>	<p>Fitness reimbursement up to \$150 per subscriber at a fitness facility per calendar year. Must be an active member of the THP and fitness facility for 4 months.</p> <p>Discount at Weight Watchers®</p>	<p>It Fits! Program reimburses families up to \$400 per family contract (\$200 for individual contracts) to use toward health club memberships, Pilates, Yoga classes, Weight Watchers® programs, and local, school sports programs and now fitness related equipment. The equipment must be new, purchased from a retail store and not Craig's List or EBay. Direct Care It Fits reimbursement \$250 / \$500.</p> <p>Other discounts also available. See plan materials for details.</p>	<p>It Fits! Program reimburses families up to \$400 per family contract (\$200 for individual contracts) to use toward health club memberships, Pilates, Yoga classes, Weight Watchers® programs, and local, school sports programs and now fitness related equipment. The equipment must be new, purchased from a retail store and not Craig's List or EBay. Direct Care It Fits reimbursement \$250 / \$500.</p> <p>Other discounts also available. See plan materials for details.</p>
<p>* Fallon DirectCare - Members now have access to Acton Medical Associates, Charles River Medical Associates and Southboro Medical Group, Fallon Clinic, Highland Healthcare Associates IPA, Lahey Clinic, Lawrence General IPA, Lowell General PHO, Mount Auburn Cambridge IPA, and Northeast PHO.</p> <p>**FCHP SelectCare - Members have access to FCHP Clinic providers, as well as hundreds of private practice physicians in Central, Northern, Eastern and Southeastern, Massachusetts.</p>												

Exhibit 5
GIC Option

			Current Program	GIC With Contribution Change Fallon Sr/ Tufts Medicare Pref	Change From Current	Percent	
Employer Share (Active)			\$7,856,929.20	\$7,248,736.76	(\$608,192.44)	-7.74%	
Employer Share (Medicare)			\$863,328.60	\$847,918.62	(\$15,409.98)	-1.78%	
		Total	\$8,720,257.80	\$8,096,655.38	(\$623,602.42)	-7.15%	
Employee/Retiree Share (Active)			\$3,050,614.80	\$2,789,979.40	(\$260,635.40)	-8.54%	
Retiree Share (Medicare)			\$594,707.40	\$638,738.46	\$44,031.06	7.40%	
		Total	\$3,645,322.20	\$3,428,717.86	(\$216,604.34)	-5.94%	
Total Cost (Active)			\$10,907,544.00	\$10,038,716.16	(\$868,827.84)	-7.97%	
Total Cost (Medicare)			\$1,458,036.00	\$1,486,657.08	\$28,621.08	1.96%	
		Total	\$12,365,580.00	\$11,525,373.24	(\$840,206.76)	-6.79%	
HP PPO to Unicare Idemnity	F	Tn	\$1,943.00	\$1,042.58	(\$900.42)	-46.34%	(\$10,805.04)
	0	Em	\$1,943.00	\$1,042.58	(\$900.42)	-46.34%	(\$10,805.04)
			\$3,886.00	\$2,085.16	(\$1,800.84)	-46.34%	
	I	Tn	\$875.00	\$446.47	(\$428.53)	-48.97%	(\$5,142.36)
	6	Em	\$875.00	\$446.47	(\$428.53)	-48.97%	(\$5,142.36)
			\$1,750.00	\$892.94	(\$857.06)	-48.97%	
Blue Choice to Tufts Navigator	F	Tn	\$1,011.00	\$878.39	(\$132.61)	-13.12%	(\$1,591.32)
	4	Em	\$674.00	\$585.59	(\$88.41)	-13.12%	(\$1,060.92)
			\$1,685.00	\$1,463.98	(\$221.02)	-13.12%	
	I	Tn	\$376.80	\$360.22	(\$16.58)	-4.40%	(\$198.96)
	2	Em	\$251.20	\$240.14	(\$11.06)	-4.40%	(\$132.72)
			\$628.00	\$600.36	(\$27.64)	-4.40%	
Tufts Navigator	F	Tn	\$1,012.80	\$878.39	(\$134.41)	-13.27%	(\$1,612.92)
	7	Em	\$675.20	\$585.59	(\$89.61)	-13.27%	(\$1,075.32)
			\$1,688.00	\$1,463.98	(\$224.02)	-13.27%	
	I	Tn	\$387.00	\$360.22	(\$26.78)	-6.92%	(\$321.36)
	0	Em	\$258.00	\$240.14	(\$17.86)	-6.92%	(\$214.32)
			\$645.00	\$600.36	(\$44.64)	-6.92%	
HPHC	F	Tn	\$954.00	\$766.62	(\$187.38)	-19.64%	(\$2,248.56)
	35	Em	\$636.00	\$511.08	(\$124.92)	-19.64%	(\$1,499.04)
			\$1,590.00	\$1,277.70	(\$312.30)	-19.64%	
	I	Tn	\$366.00	\$314.19	(\$51.81)	-14.16%	(\$621.72)
	48	Em	\$244.00	\$209.46	(\$34.54)	-14.16%	(\$414.48)
			\$610.00	\$523.65	(\$86.35)	-14.16%	

			Current Program	GIC With Contribution Change Fallon Sr/ Tufts Medicare Pref	Change From Current	Percent	
Employer Share - Fallon Select	F	Tn	\$1,065.80	\$1,004.56	(\$61.24)	-5.75%	(\$734.88)
	364	Em	\$394.20	\$371.55	(\$22.65)	-5.75%	(\$271.80)
			\$1,460.00	\$1,376.11	(\$83.89)	-5.75%	
	I	Tn	\$395.66	\$418.57	\$22.91	5.79%	\$274.92
	217	Em	\$146.34	\$154.81	\$8.47	5.79%	\$101.64
			\$542.00	\$573.38	\$31.38	5.79%	
Employer Share - Fallon Direct	F	Tn	\$1,058.46	\$850.82	(\$207.64)	-19.62%	(\$2,491.68)
	88	Em	\$298.54	\$239.98	(\$58.56)	-19.62%	(\$702.72)
			\$1,357.00	\$1,090.80	(\$266.20)	-19.62%	
	I	Tn	\$393.90	\$354.51	(\$39.39)	-10.00%	(\$472.68)
	50	Em	\$111.10	\$99.99	(\$11.11)	-10.00%	(\$133.32)
			\$505.00	\$454.50	(\$50.50)	-10.00%	
HP Medicare Enhanced	I	Tn	\$189.00	\$193.72	\$4.72	2.50%	\$56.64
	170	Rt	\$189.00	\$193.72	\$4.72	2.50%	\$56.64
			\$378.00	\$387.44	\$9.44	2.50%	
MEDEX III to Medicare Enhanced	I	Tn	\$212.00	\$193.72	(\$18.28)	-8.62%	(\$219.36)
	6	Rt	\$212.00	\$193.72	(\$18.28)	-8.62%	(\$219.36)
			\$424.00	\$387.44	(\$36.56)	-8.62%	
Tufts Medicare Plus to Compliment	I	Tn	\$166.00	\$195.48	\$29.48	17.76%	\$353.76
	27	Rt	\$166.00	\$195.48	\$29.48	17.76%	\$353.76
			\$332.00	\$390.96	\$58.96	17.76%	
BC/BS Managed Blue to Medicare Enhanced	I	Tn	\$241.20	\$193.72	(\$47.48)	-19.68%	(\$569.76)
	4	Rt	\$160.80	\$193.72	\$32.92	20.47%	\$395.04
			\$402.00	\$387.44	(\$14.56)	-3.62%	
Fallon Senior	I	Tn	\$209.25	\$192.40	(\$16.85)	-8.05%	(\$202.20)
	153	Rt	\$69.75	\$82.46	\$12.71	18.22%	\$152.52
			\$279.00	\$274.86	(\$4.14)	-1.48%	
Tufts Medicare Preferred	I	Tn	\$180.00	\$177.99	(\$2.01)	-1.12%	(\$24.12)
	6	Rt	\$60.00	\$76.28	\$16.28	27.13%	\$195.36
			\$240.00	\$254.27	\$14.27	5.95%	

HEALTH PLAN	PLAN TYPE	INDIVIDUAL	FAMILY
Fallon Community Health Plan Direct Care	HMO	\$454.50	\$1,090.80
Fallon Community Health Plan Select Care	HMO	573.38	1,376.11
Harvard Pilgrim Independence Plan	PPO	654.56	1,597.13
Harvard Pilgrim Primary Choice Plan	HMO	523.65	1,277.70
Health New England	HMO	445.15	1,103.63
NHP Care (<i>Neighborhood Health Plan</i>)	HMO	475.84	1,260.93
Tufts Health Plan Navigator	PPO	600.36	1,463.98
Tufts Health Plan Spirit	HMO-type	478.41	1,166.63
UniCare State Indemnity Plan/Basic with CIC (Comprehensive)	Indemnity	892.93	2,085.15
UniCare State Indemnity Plan/Basic without CIC (Non-Comprehensive)	Indemnity	852.09	1,990.42
UniCare State Indemnity Plan/Community Choice	PPO-type	423.67	1,016.79
UniCare State Indemnity Plan/PLUS	PPO-type	577.78	1,379.15

Medicare Plans

Health Plan	PLAN TYPE	PER PERSON
Fallon Senior Plan*	Medicare (HMO)	\$274.86
Harvard Pilgrim Medicare Enhance	Medicare (Indemnity)	387.44
Health New England MedPlus	Medicare (HMO)	359.59
Tufts Health Plan Medicare Complement	Medicare (HMO)	390.95
Tufts Health Plan Medicare Preferred*	Medicare (HMO)	254.27
UniCare State Indemnity Plan/Medicare Extension (OME) with CIC (Comprehensive)	Medicare (Indemnity)	373.53
UniCare State Indemnity Plan/Medicare Extension (OME) without CIC (Non-Comprehensive)	Medicare (Indemnity)	362.82

**Benefits and rates of Fallon Senior Plan and Tufts Health Plan Medicare Preferred are subject to federal approval and may change January 1, 2013.*

Benefits	WSHG Benchmark	GIC			
		Direct Care	Select Care		
			Tier 1	Tier 2	Tier 3
Deductible	\$250 individual / \$750 family	\$250 individual / \$750 family		\$250 individual / \$750 family	
Out-of-pocket maximum	\$2,000 individual / \$4,000 family	None		None	
Office	WSHG Benchmark	Direct Care	Tier 1	Tier 2	Tier 3
Routine physical exams (according to MHQP preventive guidelines)	\$0 per visit	\$0 per visit		\$0 per visit	
Office visits (primary care provider)	\$20 per visit	\$15 per visit		\$20 per visit	
Office visits (specialist)	\$35 per visit	\$25 per visit	\$25 per visit	\$35 per visit	\$45 per visit
Routine eye exams (one every 12 months)	\$0 per visit	\$15 per visit		\$20 per visit	
Short-term rehabilitative services (60 visits per illness or injury)	\$20 per visit	\$15 per visit		\$20 per visit	
Prenatal care	\$20 first visit only	\$15 per visit	\$15 per visit	\$20 per visit	\$30 per visit
Postnatal care	\$20 per visit	\$15 per visit		\$15 per visit	\$20 per visit
Preventive services	Covered in full	Covered in full		Covered in full	
Diagnostic services	Covered in full after deductible	Covered in full after deductible		Covered in full after deductible	
Imaging (CAT, PET, MRI)	\$100 copay then deductible	\$100 copay then deductible		\$100 copay then deductible	
Chiropractic care (12 visits per calendar year)	\$20 per visit	\$15 per visit		\$20 per visit	
Prescriptions	Tier 1/Tier 2/Tier 3	Tier 1/Tier 2/Tier 3	Tier 1/Tier 2/Tier 3		
Prescription drugs, including oral contraceptives, insulin and insulin syringes	\$10/\$25/\$50 (30-day supply)	\$10/\$25/\$50 (30-day supply)		\$10/\$25/\$50 (30-day supply)	
Prescription medication refills obtained through the mail order program	\$20/\$50/\$110 (90-day supply)	\$20/\$50/\$110 (90-day supply)		\$20/\$50/\$110 (90-day supply)	
Inpatient hospital services	WSHG Benchmark	Direct Care	Tier 1	Tier 2	Tier 3
Room and board in a semiprivate room (private when medically necessary)	\$300 copay then deductible	\$200 copay then deductible	\$250 copay then deductible	\$500 copay then deductible	\$750 copay then deductible
Same-day surgery	WSHG Benchmark	Direct Care	Tier 1	Tier 2	Tier 3
Same-day surgery in a hospital outpatient or ambulatory care setting	\$150 per surgery then deductible	\$110 copayment then deductible	\$125 copayment then deductible		
Emergencies	WSHG Benchmark	Direct Care	Tier 1	Tier 2	Tier 3
Emergency room visit	\$100 copay then deductible	\$100 copay then deductible		\$100 copay then deductible	
Skilled nursing	WSHG Benchmark	Direct Care	Tier 1	Tier 2	Tier 3
Skilled care in a semiprivate room	\$300 copay then deductible	Covered in full after deductible		Covered in full after deductible	
Substance abuse	WSHG Benchmark	Direct Care	Tier 1	Tier 2	Tier 3
Office visits	\$20 per visit	\$15 per visit		\$20 per visit	
Detoxification in an inpatient setting	Covered in full	Covered in full		Covered in full	
Up to 30 days rehabilitation in an inpatient setting	Covered in full	Covered in full		Covered in full	
Mental health	WSHG Benchmark	Direct Care	Tier 1	Tier 2	Tier 3
Office visits	\$20 per visit	\$15 per visit		\$20 per visit	
Services in a general or psychiatric hospital	Covered in full	Covered in full		Covered in full	
Other health services	WSHG Benchmark	Direct Care	Tier 1	Tier 2	Tier 3
Skilled home health care services	Subject to deductible then covered in full	Subject to deductible then covered in full		Subject to deductible then covered in full	
Durable medical equipment	Covered in full after deductible	20% coinsurance after deductible		20% coinsurance after deductible	
Medically necessary ambulance services	Covered in full	Covered in full after deductible		Covered in full after deductible	

Exhibit 6

Chapter 32 B
Section 21, Section 22 & Section 23



PART I ADMINISTRATION OF THE GOVERNMENT
(Chapters 1 through 182)

TITLE IV CIVIL SERVICE, RETIREMENTS AND PENSIONS

CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS

Section 21 Manner of changing health insurance benefits; estimation of savings; approval of agreement; immediate implementation; time for review; distribution of savings; regulations

[Subsection (a) effective until June 19, 2012. For text effective June 19, 2012, see below.]

Section 21. (a) Any political subdivision electing to change health insurance benefits under sections 22 or 23 shall do so in the following manner: in a county, except Worcester county, by a vote of the county commissioners; in a city having Plan D or a Plan E charter, by majority vote of the city council and approval by the manager; in any other city, by majority vote of the city council and approval by the mayor; in a town, by vote of the board of selectmen; in a regional school district, by vote of the regional district school committee; and in all other districts, by vote of the registered voters of the district at a district meeting. This section shall be binding on any political subdivision that implements changes to health insurance benefits pursuant to section 22 or 23.

[Subsection (a) as amended by 2012, 118, Sec. 10 effective June 19, 2012. For text effective until June 19, 2012, see above.]

(a) Any political subdivision electing to change health insurance benefits under sections 22 or 23 shall do so in the following manner: in a county, except Worcester county, by a vote of the county commissioners; in a city having Plan D or a Plan E charter, by majority vote of the city council and approval by the manager; in any other city, by majority vote of the city council and approval by the mayor; in a town, by vote of the board of selectmen; in a regional school district, by vote of the regional district school committee; and in all other districts, by vote of the registered voters of the district at a district meeting or by vote of the district's governing board. This section shall be binding on any political subdivision that implements changes to health insurance benefits pursuant to section 22 or 23.

(b) Prior to implementing any changes authorized under sections 22 or 23, the appropriate public authority shall evaluate its health insurance coverage and determine the savings that may be realized after the first 12 months of implementation of plan design changes or upon transfer of its subscribers to the commission. The appropriate public authority shall then notify its insurance advisory committee, or such committee's regional or district equivalent, of the estimated savings and provide any reports or other documentation with respect to the

determination of estimated savings as requested by the insurance advisory committee. After discussion with the insurance advisory committee as to the estimated savings, the appropriate public authority shall give notice to each of its collective bargaining units to which the authority provides health insurance benefits and a retiree representative, hereafter called the public employee committee, of its intention to enter into negotiations to implement changes to health insurance benefits provided by the appropriate public authority. The retiree representative shall be designated by the Retired State, County and Municipal Employees Association. A political subdivision which has previously established a public employee committee under section 19 may implement changes to its health insurance benefits pursuant to this section and sections 22 and 23.

Notice to the collective bargaining units and retirees shall be provided in the same manner as prescribed in section 19. The notice shall detail the proposed changes, the appropriate public authority's analysis and estimate of its anticipated savings from such changes and a proposal to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected.

(c) The appropriate public authority and the public employee committee shall have not more than 30 days from the point at which the public employee committee receives the notice as provided in subsection (b) to negotiate all aspects of the proposal. An agreement with the appropriate public authority shall be approved by a majority vote of the public employee committee; provided, however, that the retiree representative shall have a 10 per cent vote. If after 30 days the appropriate public authority and public employee committee are unable to enter into a written agreement to implement changes under section 22 or 23, the matter shall be submitted to a municipal health insurance review panel. The panel shall be comprised of 3 members, 1 of whom shall be appointed by the public employee committee, 1 of whom shall be appointed by the public authority and 1 of whom shall be selected through the secretary of administration and finance who shall forward to the appropriate public authority and the public employee committee a list of 3 impartial potential members, each of whom shall have professional experience in dispute mediation and municipal finance or municipal health benefits, from which the appropriate public authority and the public employee committee may jointly select the third member; provided, however, that if the appropriate public authority and the public employee committee cannot agree within 3 business days upon which person to select as the third member of the panel, the secretary of administration and finance shall select the final member of the panel. Any fee or compensation provided to a member for service on the panel shall be shared equally between the public employee committee and the appropriate public authority.

(d) The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 22; provided,

however, that any increases to plan design features have been made in accordance with the provisions of section 22. The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 23; provided, that the panel confirms that the anticipated savings under those changes would be at least 5 per cent greater than the maximum possible savings under section 22. If the panel does not approve implementation of changes made pursuant to section 22 or section 23, the public authority may submit a new proposal to the public employee committee for consideration and confirmation under this section.

(e) Within 10 days of receiving any proposed changes under sections 22 or 23, the municipal health insurance review panel shall: (i) confirm the appropriate public authority's estimated monetary savings due to the proposed changes under section 22 or 23 and ensure that the savings is substantiated by documentation provided by the appropriate public authority; provided, however, that if the panel determines the savings estimate to be unsubstantiated, the panel may require the public authority to submit a new estimate or provide additional information to substantiate the estimate; (ii) review the proposal submitted by the appropriate public authority to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected; and (iii) concur with the appropriate public authority that the proposal is sufficient to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected or revise the proposal pursuant to subsection (f).

(f) The municipal health insurance review panel may determine the proposal to be insufficient and may require additional savings to be shared with subscribers, particularly those who would be disproportionately affected by changes made pursuant to sections 22 or 23, including retirees, low-income subscribers and subscribers with high out-of-pocket costs. In evaluating the distribution of savings to retirees, the panel may consider any discrepancy between the percentage contributed by retirees, surviving spouses and their dependents to plans offered by the public authority as compared to other subscribers. In reaching a decision on the proposal under this subsection, the municipal health insurance review panel may consider an alternative proposal, with supporting documentation, from the public employee committee to mitigate, moderate or cap the impact of these changes for subscribers. The panel may require the appropriate public authority to distribute additional savings to subscribers in the form of health reimbursement arrangements, wellness programs, health care trust funds for emergency medical care or inpatient hospital care, out-of-pocket caps, Medicare Part B reimbursements or reimbursements for other qualified medical expenses; provided, however that in no case shall the municipal health insurance review panel designate more than 25 per cent of the estimated savings to subscribers. The municipal

health insurance review panel shall not require a municipality to implement a proposal to mitigate, moderate or cap the impact of changes authorized under section 22 or 23 which has a total multi-year cost that exceeds 25 per cent of the estimated savings. All obligations on behalf of the appropriate public authority related to the proposal shall expire after the initial amount of estimated savings designated by the panel to be distributed to employees and retirees has been expended. The panel shall not impose any change to contribution ratios.

(g) The decision of the municipal health insurance review panel shall be binding upon all parties.

(h) The secretary of administration and finance shall promulgate regulations establishing administrative procedures for the negotiations with the public employee committee and the municipal health insurance review panel, and issue guidelines to be utilized by the appropriate public authority and the municipal health insurance review panel in evaluating which subscribers are disproportionately affected, subscriber income and subscriber out-of-pocket costs associated with health insurance benefits.



PART I ADMINISTRATION OF THE GOVERNMENT
(Chapters 1 through 182)

TITLE IV CIVIL SERVICE, RETIREMENTS AND PENSIONS

CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS

Section 22 Copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features; increases

[Text of section added by 2011, 69, Sec. 3 effective July 12, 2011.]

Section 22. (a) Upon meeting the requirements of section 21, an appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers by acceptance of any other section of this chapter may include, as part of the health plans that it offers to its subscribers not enrolled in a Medicare plan under section 18A, copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment; provided, however, that for subscribers enrolled in a Medicare plan pursuant to section 18A the appropriate public authority may include, as part of the health plans that it offers to its subscribers, copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment. The appropriate public authority shall not include a plan design feature which seeks to achieve premium savings by offering a health benefit plan with a reduced or selective network of providers unless the appropriate public authority also offers a health benefit plan to all subscribers that does not contain a reduced or selective network of providers.

(b) An appropriate public authority may increase the dollar amounts for copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features; provided that, for subscribers enrolled in a non-Medicare plan, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment and, for subscribers enrolled in a Medicare plan under section 18A, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment; provided, however, that the public authority need only satisfy the requirements of subsection (a) of section 21 the first time changes are implemented

pursuant to this section; and provided, further that the public authority meet its obligations under subsections (b) to (h), inclusive, of section 21 each time an increase to a plan design feature is proposed.

Nothing herein shall prohibit an appropriate public authority from including in its health plans higher copayments, deductibles or tiered provider network copayments or other plan design features than those authorized by this section; provided, however, such higher copayments, deductibles, tiered provider network copayments and other plan design features may be included only after the governmental unit has satisfied any bargaining obligations pursuant to section 19 or chapter 150E.

(c) The decision to accept and implement this section shall not be subject to bargaining pursuant to chapter 150E or section 19. Nothing in this section shall preclude the implementation of plan design changes pursuant to this section in communities that have adopted section 19 of this chapter or by the governing board of a joint purchasing group established pursuant to section 12.

(d) Nothing in this section shall relieve an appropriate public authority from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter.

(e) The first time a public authority implements plan design changes under this section or section 23, the public authority shall not increase before July 1, 2014, the percentage contributed by retirees, surviving spouses and their dependents to their health insurance premiums from the percentage that was approved by the public authority prior to and in effect on July 1, 2011; provided however, that if a public authority approved of an increase in said percentage contributed by retirees before July 1, 2011, but to take effect on a date after July 1, 2011, said percentage increase may take effect upon the approval of the secretary of administration and finance based on documented evidence satisfactory to the secretary that the public authority approved the increase prior to July 1, 2011.



PART I ADMINISTRATION OF THE GOVERNMENT
(Chapters 1 through 182)

TITLE IV CIVIL SERVICE, RETIREMENTS AND PENSIONS

CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS

Section 23 Transfer of subscribers to commission; notice; transfer to Medicare of eligible subscribers; withdrawal from commission coverage; group coverage provided by commission; deficit in claims trust fund by self-insured political subdivision; administration of coverage for transferred subscribers by commission; reimbursement of commission for coverage costs; withdrawal from commission

[First paragraph of subsection (a) effective until June 19, 2012. For text effective June 19, 2012, see below.]

Section 23. (a) Upon meeting the requirements of section 21, an appropriate public authority which has undertaken to provide health insurance coverage to its subscribers may elect to provide health insurance coverage to its subscribers by transferring its subscribers to the commission and shall notify the commission of such transfer. The notice shall be provided to the commission by the appropriate public authority on or before December 1 of each year and the transfer of subscribers to the commission shall take effect on the following July 1. On the effective date of the transfer, the health insurance of all subscribers, including elderly governmental retirees previously governed by section 10B of chapter 32A and retired municipal teachers previously governed by section 12 of chapter 32A, shall be provided through the commission for all purposes and governed under this section. As of the effective date and for the duration of this transfer, subscribers transferred to the commission's health insurance coverage shall receive group health insurance benefits determined exclusively by the commission and the coverage shall not be subject to collective bargaining, except for contribution ratios.

[First paragraph of subsection (a) as amended by 2012, 118, Sec. 11 effective June 19, 2012. For text effective until June 19, 2012, see above.]

(a) Upon meeting the requirements of section 21, an appropriate public authority which has undertaken to provide health insurance coverage to its subscribers may elect to provide health insurance coverage to its subscribers by transferring its subscribers to the commission and shall notify the commission of such transfer. The notice shall be provided to the commission by the appropriate public authority on or before December 1 of each year for the transfer of subscribers to the commission effective the following July 1, or on or before July 1 of each year for the transfer of subscribers to the commission effective the following January 1. On the effective date of the transfer, the health insurance of all subscribers, including

elderly governmental retirees previously governed by section 10B of chapter 32A and retired municipal teachers previously governed by section 12 of chapter 32A, shall be provided through the commission for all purposes and governed under this section. As of the effective date and for the duration of this transfer, subscribers transferred to the commission's health insurance coverage shall receive group health insurance benefits determined exclusively by the commission and the coverage shall not be subject to collective bargaining, except for contribution ratios.

Subscribers transferred to the commission who are eligible or become eligible for Medicare coverage shall transfer to Medicare coverage, as prescribed by the commission. In the event of transfer to Medicare, the political subdivision shall pay any Medicare part B premium penalty assessed by the federal government on retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan. For each subscriber's premium and the political subdivision's share of that premium, the subscriber and the political subdivision shall furnish to the commission, in such form and content as the commission shall prescribe, all information the commission deems necessary to maintain subscribers' and covered dependents' health insurance coverage. The appropriate public authority of the political subdivision shall perform such administrative functions and process such information as the commission deems necessary to maintain those subscribers' health insurance coverage including, but not limited to, family and personnel status changes, and shall report all changes to the commission. In the event that a political subdivision transfers subscribers to the commission under this section, subscribers may be withdrawn from commission coverage at 3 year intervals from the date of transfer of subscribers to the commission.

The appropriate public authority shall provide notice of any withdrawal by October 1 of the year prior to the effective date of withdrawal. All withdrawals shall be effective on July 1 following the political subdivision's notice to the commission and the political subdivision shall abide by all commission requirements for effectuating such withdrawal, including the notice requirements in this subsection. In the event a political subdivision withdraws from commission coverage under this section, such withdrawal shall be binding on all subscribers, including those subscribers who, prior to the transfer to the commission, received coverage from the commission under sections 10B and 12 of chapter 32A and, after withdrawal from the commission, those subscribers who received coverage from the commission under said sections 10B and 12 of said chapter 32A shall not pay more than 25 per cent of the cost of their health insurance premiums. In the event of withdrawal from the commission, the political subdivision and public employee unions shall return to governance of negotiations of health insurance under chapter 150E and this chapter; provided, however, that the political subdivision may transfer coverage to the commission again after complying with the requirements of subsections (b) to (h), inclusive, of section 21.

The commission shall issue rules and regulations consistent with this section related to the process by which subscribers shall be transferred to the commission.

(b) To the extent authorized under chapter 32A, the commission shall provide group coverage of subscribers' health claims incurred after transfer to the commission. The claim experience of those subscribers shall be maintained by the commission in a single pool and combined with the claim experience of all covered state employees and retirees and their covered dependents, including those subscribers who previously received coverage under sections 10B and 12 of chapter 32A.

(c) A political subdivision that self-insures its group health insurance plan under section 3A and has a deficit in its claims trust fund at the time of transferring its subscribers to the commission and the deficit is attributable to a failure to accrue claims which had been incurred but not paid may capitalize the deficit and amortize the amount over 10 fiscal years in 10 equal amounts or on a schedule providing for a more rapid amortization. Except as provided otherwise herein, subscribers eligible for health insurance coverage pursuant to this section shall be subject to all of the terms, conditions, schedule of benefits and health insurance carriers as employees and dependents as defined by section 2 and commission regulations. The commission shall, exclusively and not subject to collective bargaining under chapter 150E, determine all matters relating to subscribers' group health insurance rights, responsibilities, costs and payments and obligations excluding contribution ratios, including, but not limited to, the manner and method of payment, schedule of benefits, eligibility requirements and choice of health insurance carriers. The commission may issue rules and regulations consistent with this section and shall provide public notice, and notice at the request of the interested parties, of any proposed rules and regulations and provide an opportunity to review and an opportunity to comment on those proposed rules and regulations in writing and at a public hearing; provided, however, that the commission shall not be subject to chapter 30A.

(d) The commission shall negotiate and purchase health insurance coverage for subscribers transferred under this section and shall promulgate regulations, policies and procedures for coverage of the transferred subscribers. The schedule of benefits available to transferred subscribers shall be determined by the commission pursuant to chapter 32A. The commission shall offer those subscribers the same choice as to health insurance carriers and benefits as those provided to state employees and retirees. The political subdivision's contribution to the cost of health insurance coverage for transferred subscribers shall be as determined under this section, and shall not be subject to the provisions on contributions in said chapter 32A. Any change to the premium contribution ratios shall become effective on July 1 of each year, with notice to the commission of such change not later than January 15 of the same year.

(e) A political subdivision that transfers subscribers to the commission shall pay the commission for all costs of its subscribers' coverage, including administrative expenses and the governmental unit's cost of subscribers' premium. The commission shall determine on a periodic basis the amount of premium which the political subdivision shall pay to the commission. If the political subdivision unit fails to pay all or a portion of these costs according to the timetable determined by the commission, the commission may inform the state treasurer who shall issue a warrant in the manner provided by section 20 of chapter 59 requiring the respective political subdivision to pay into the treasury of the commonwealth as prescribed by the commission the amount of the premium and administrative expenses attributable to the political subdivision. The state treasurer shall recoup any past due costs from the political subdivision's cherry sheet under section 20A of chapter 58 and transfer that money to the commission. If a governmental unit fails to pay to the commission the costs of coverage for more than 90 days and the cherry sheet provides an inadequate source of payment, the commission may, at its discretion, cancel the coverage of subscribers of the political subdivision. If the cancellation of coverage is for nonpayment, the political subdivision shall provide all subscribers health insurance coverage under plans which are the actuarial equivalent of plans offered by the commission in the preceding year until there is an agreement with the public employee committee providing for replacement coverage.

The commission may charge the political subdivision an administrative fee, which shall not be more than 1 per cent of the cost of total premiums for the political subdivision, to be determined by the commission which shall be considered as part of the cost of coverage to determine the contributions of the political subdivision and its employees to the cost of health insurance coverage by the commission.

(f) If there is a withdrawal from the commission under this section, all retirees, their spouses and dependents insured or eligible to be insured by the political subdivision, if enrolled in Medicare part A at no cost to the retiree, spouse or dependents, shall be required to be insured by a Medicare extension plan offered by the political subdivision under section 11C or section 16. A retiree shall provide the political subdivision, in such form as the political subdivision shall prescribe, such information as is necessary to transfer to a Medicare extension plan. If a retiree does not submit the information required, the retiree shall no longer be eligible for the retiree's existing health insurance coverage. The political subdivision may from time to time request from a retiree, a retiree's spouse and dependents, proof certified by the federal government of the retiree's eligibility or ineligibility for Medicare part A and part B coverage. The political subdivision shall pay the Medicare part B premium penalty assessed by the federal government on those retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan.

(g) The decision to implement this section shall not be subject to collective bargaining pursuant to chapter 150E or section 19.

(h) Nothing in this section shall relieve a political subdivision from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter or change eligibility standards for health insurance under the definition of "employee" in section 2.

[Subsection (i) added by 2012, 139, Sec. 67 effective July 1, 2012. See 2012, 139, Sec. 229.]

(i) Notwithstanding any other general or special law to the contrary, in the event that an agreement, either executed or modified, was reached by an appropriate public authority and the public employee committee to transfer all subscribers, for whom the authority provides health insurance coverage, to the commission under this section, its retirees, surviving spouses and their dependents may enroll in the dental insurance plan provided by the commission to retirees, surviving spouses and their dependents insured under chapter 32A, at premium contribution ratios that requires retirees, surviving spouses and their dependents to contribute 100 per cent of the dental insurance premium and administrative fee. The commission shall provide dental insurance coverage, under its plan for retirees, surviving spouses and their dependents insured under chapter 32A, to retirees, surviving spouses and their dependents who elect the coverage under this subsection, as it so provides health insurance coverage under this section. The commission may charge an administrative fee, which shall not be more than 1 per cent of the cost of total dental insurance premiums for the retirees, surviving spouses and their dependents who enroll in the dental insurance plan under this subsection, to be determined by the commission which shall be considered as part of the cost of coverage for purposes of determining the contributions of the political subdivision and its retirees, surviving spouses and their dependents to the cost of insurance coverage by the commission.