TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2019-2020
JUNE PAYROLL CHANGES FOR JULY 1, 2019 OPEN-ENROLLMENT

% PAID TOWN/EMP	PLAN TYPE	TOTAL MONTHLY		TOWN MONTHLY	TOWN 26 P/R BI-WEEKLY	TOWN 21 P/R BI-WEEKLY*		EMPLOYEE MONTHLY	EMP. 26 P/R BI-WEEKLY	EMP. 21P/R BI-WEEKLY*		COBRA
BENCHMARK HMO PLANS												
BLUE CROSS NETWORK BLUE BENCHMARK												
60/40	**FAMILY**	***$2,759.00***		$1,655.40	$764.03	$945.94		**$1,103.60**	**$509.35**	**$630.63**		$2,814.18
50/50	FAMILY (SS)	***$2,759.00***		$1,379.50	$636.69	$788.29		$1,379.50	$636.69	$788.29		
60/40	**INDIVIDUAL**	***$1,029.00***		$617.40	$284.95	$352.80		**$411.60**	**$189.97**	**$235.20**		
50/50	INDIVIDUAL (SS)	***$1,029.00***		$514.50	$237.46	$294.00		$514.50	$237.46	$294.00		$1,049.58
TUFTS BENCHMARK												
60/40	**FAMILY**	***$2,709.00***		$1,625.40	$750.18	$928.80		**$1,083.60**	**$500.12**	**$619.20**		$2,763.18
50/50	FAMILY (SS)	***$2,709.00***		$1,354.50	$625.15	$774.00		$1,354.50	$625.15	$774.00		
60/40	**INDIVIDUAL**	***$1,035.00***		$621.00	$286.62	$354.86		**$414.00**	**$191.08**	**$236.57**		$1,055.70
50/50	INDIVIDUAL (SS)	***$1,035.00***		$517.50	$238.85	$295.71		$517.50	$238.85	$295.71		
HPHC BENCHMARK												
60/40	**FAMILY**	***$2,524.00***		$1,514.40	$698.95	$865.37		**$1,009.60**	**$465.97**	**$576.91**		$2,574.48
50/50	FAMILY (SS)	***$2,524.00***		$1,262.00	$582.46	$721.14		$1,262.00	$582.46	$721.14		
60/40	**INDIVIDUAL**	***$969.00***		$581.40	$268.34	$332.23		**$387.60**	**$178.89**	**$221.49**		$988.38
50/50	INDIVIDUAL (SS)	***$969.00***		$484.50	$223.62	$276.86		$484.50	$223.62	$276.86		
FALLON SELECT BENCHMARK												
73/27	**FAMILY**	***$2,032.00***		$1,483.36	$684.63	$847.63		**$548.64**	**$253.22**	**$313.51**		$2,072.64
50/50	FAMILY (SS)	***$2,032.00***		$1,016.00	$468.92	$580.57		$1,016.00	$468.92	$580.57		
73/27	**INDIVIDUAL**	***$754.00***		$550.42	$254.04	$314.53		**$203.58**	**$93.96**	**$116.33**		$769.08
50/50	INDIVIDUAL (SS)	***$754.00***		$377.00	$174.00	$215.43		$377.00	$174.00	$215.43		
FALLON DIRECT BENCHMARK												
78/22	**FAMILY**	***$1,890.00***		$1,474.20	$680.40	$842.40		**$415.80**	**$191.91**	**$237.60**		$1,927.80
50/50	FAMILY (SS)	***$1,890.00***		$945.00	$436.15	$540.00		$945.00	$436.15	$540.00		
78/22	**INDIVIDUAL**	***$702.00***		$547.56	$252.72	$312.89		**$154.44**	**$71.28**	**$88.25**		$716.04
50/50	INDIVIDUAL (SS)	***$702.00***		$351.00	$162.00	$200.57		$351.00	$162.00	$200.57		

(SS) REPRESENTS SURVIVING SPOUSE

SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)

WEST SUBURBAN HEALTH GROUP

Effective 07-01-2019

BENCHMARK HEALTH PLAN COMPARISON CHART July 1, 2019

red font indicates change or clarification	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None
Deductible - 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*	IND $300 FAM $900	IND $300 FAM $900	IND $300 FAM $900	IND $300 FAM $900
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. Effective July 1, 2015, out-of-pocket maximums for prescription copays have been added as required by ACA (in-network only).	**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year see plan for details	**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year see plan for details	**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year see plan for details	**Medical & Prescription Combined -** $2,000 Individual per plan year $4,000 Family per plan year
Family Covered	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
Selection of Primary Care Physician (PCP)	Member must select	Member must select	No selection required	Member must select
Specialist Referrals	PCP must refer	PCP must refer	No referral required	PCP must refer
Providers of Service	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities throughtout Massachusetts, southern New Hampshire and southwestern Vermont. ***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
INPATIENT				
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Deductible applies then: Tier 1 : $250 Tier 2 :$500 Tier 3 : $1500 per/Admit NOTE-Mental Health/Substance Abuse copay $250	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay	Semi-private room & board & ancillary services Tier 1: $500 copay, then deductible applies Tier 2: $1500 copay, then deductible applies NOTE-Mental Health/Substance Abuse	$500 copay per admission, then deductible No co-pay or deductible for Mental Hospital/Substance Abuse Facility

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PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Physician Services	Nothing	Nothing	Nothing	Nothing, after deductible
Skilled Nursing Facility	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then covered in full	Covered in Full after Deductible, up to 100 days per plan year	$500 copay per admission, then deductible Max of 100 days per year.
Newborn Well Baby Care (Inpatient)	Nothing	Nothing	Nothing	Nothing
OUTPATIENT				
Emergency Room Visits for Emergency or Accident Care	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	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	$100 copay, then deductible applies (Inpatient copay applies if admitted)	$100 copay, then deductible applies (waived if admitted, then Inpatient copay applies)
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible applies, then $250 copay per visit	Deductible applies, then $250 copay per visit	$250 copay per outpatient surgery, then deductible	$250 copay per outpatient surgery, then deductible
CT, MRI and Pet Scans	Deductible applies, then $100 Copay per procedure	Deductible, then $100 copay (scheduled outpatient)	$100 copay, then Deductible	$100 copay, then deductible
Hemodialysis	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Physical Therapy	Copay: $20 per visit - Limited to 30 visits per plan year	$20 copay; up to 60 visits per calendar year (Unlimited for autism)	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year	$20 copay. PT / OT Max limit up to 60 visits per plan year
Office Visits Primary Care Physician	$20 copay per visit	$20 copay	$20 copay per visit	$20 copay per visit
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care *(Mental Health copays excluded from OOP max)*	$20 copay per visit	$20 per visit	$20 copay per visit	$20 copay per visit
Office Visits Specialist	Tier 1 : $30 copay per visit Tier 2: $60 copay per visit Tier 3: $90 copay per visit	$60 copay per visit	$60 copay per visit	$60 copay per visit
OB/GYN	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	$0 copay - 1 every 2 years	$0 copay; one visit every 12 months	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers
Pre-Admission Testing -	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Nothing	Nothing	Nothing for prenatal and postnatal outpatient care	Prenatal: $20 copay first visit only; Postnatal: $20 copay per visit

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Dental Services	**Children up to age 13** - 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.	**Children under age 12**: Preventive dental one exam every six months., 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. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	**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.
OTHER FEATURES				
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary
Home Health Care	Member cost sharing depends on types of services provided and tier placement of provider rendering devices, 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."	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Hospice Care	Same as Home Health Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	Deductible, then CIF^	Deductible, then 20% coinsurance	Deductible, then CIF^	Deductible, then CIF^ 20% coinsurance after the deductible for prosthetic limbs which replace, in whole or in part, an arm or leg.
Ambulance	Nothing when medically necessary	Deductible then covered in full	Deductible then covered in full	Covered in full when medically necessary
Radiation Therapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	$20 copay, 20 visits per plan year	$20 copay per visit. 12 visits maximum per calendar year	$20 copay per visit; up to 12 visits per plan year	$20 copay per visit; up to 12 visits per plan year.
Prescription Drugs	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy:**
(Inpatient drugs paid in full)	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay

WEST SUBURBAN HEALTH GROUP

IMPORTANT - PLEASE READ

The attached benefit comparison chart is a high level overview of the plans offered by WSHG.

The plan documents available to registered users on the carrier websites are the documents that describe full and complete plan details.

The carrier documents are the only documents that coverage is based on.

Should you have a question about specific coverage, you will need to contact the Member Service number on your ID card for detail or visit the carrier website.