Current Plan Designs July 1, 2017

TOWN OF NANTUCKET - NON MEDICARE ELIGIBLE PLAN OPTIONS					ATTACHMENT A
Covered Services	Network Blue New England	Blue Care Elect Preferred (PPO) In-Network	Blue Care Elect Preferred (PPO) Out-Network	Master Medical	GIC Tufts Navigator (Approximated)
Deductible	None	None	$400/$800	$100/$300	$500/$1,000
Coinsurance	100%	100%	80%	100%	100%
Out of Pocket Maximum	$2,000/$4,000 Med. $1,000/$2,000 RX	$2,000/$4,000 Med $1,000/$2,000 RX	$3,000/Mbr None	$5,000/$10,000 Med $1,000/$2,000 RX	$5,000/$10,000
Preventative Care					
Well-Child Care Visits	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Routine adult exams, including tests	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Routine GYN exams, including tests	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Routine hearing exams	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Routine Vision exams	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Family planning services-office visits	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Outpatient Care					
Emergency Room visits	$25 per visit waived if admitted	$25 per visit waived if admitted		$25, no deductible waived if admitted	$100 per visit, after deductible waived if admitted
Office Visits					
PCP, OB/GYN	$20	$20	Deductible & Coinsurance	20% coinsurance after deductible	$10/$20/$40
Other network providers	$35	$35	Deductible & Coinsurance	20% coinsurance after deductible	$30/$60/$90
Chiropractor Office visits	$20	$20	Deductible & Coinsurance	20% coinsurance after deductible	$20
Mental Health or Substance Abuse	$20	$20	Deductible & Coinsurance	Nothing, no deductible	$20
Rehabilitation Therapy-Phys. & Occ.	$20	$20	Deductible & Coinsurance	20% coinsurance after deductible	$20
Speech, Hearing & language disorder	$20	$20	Deductible & Coinsurance	20% coinsurance after deductible	$20
DXL, and lab. Tests	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Covered in Full, after deductible
Diagnostic Imaging & Nuclear Imag.	$375/Mbr maximum	No Max	No Max	No Max	No Max
	$100 per	$100 per	Deductible & Coinsurance	$100 per	$100, after deductible
Home Health Care & Hospice	Nothing	Nothing	Deductible & Coinsurance	20% coinsurance after ded. Hospice covered in full	Covered in Full, after deductible
Oxygen & Equipment	Nothing	Nothing	Deductible & Coinsurance	20% coinsurance after deductible	Covered in Full, after deductible
Durable Medical Equipment	20% Coinsurance	20% Coinsurance	40% Coinsurance	20% coinsurance after deductible	30% coinsurance, after deductible
Prosthetic Devices	20% Coinsurance	20% Coinsurance	40% Coinsurance	20% coinsurance after deductible	30% coinsurance, after deductible
Surgery by: PCP or OB/GYN	$20	$20	Deductible & Coinsurance	Nothing	$20
Other network providers	$35	$35	Deductible & Coinsurance	Nothing	$30/$60/$90
Ambulatory surgical/Outpatient facility	$150 per	$150 per	Deductible & Coinsurance	$150 per	$250, after deductible
Inpatient Care	$600/$900 maximum	$600/$900 maximum	No Max	$600/$900 maximum	
General or Chronic Hospital	$300 per admission	$300 per admission	Deductible & Coinsurance	$300 per admission, no deductible	$275/$500/$1,500 per adm.
Mental or Substance Abuse Facility	$300 per admission	$300 per admission	Deductible & Coinsurance	$300 per admission, no deductible	$275/$500/$1,500 per adm.
Rehabilitation Hospital	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Skilled Nursing Facility	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Prescription Drug Coverage					
Plan Year Deductible	None	None	None	None	$100/$200
Retail - 30 day supply	$10/$25/$50	$10/$25/$50	Not Covered	$10/$25/$50	$10/$30/$65
Mail Order - 90 day supply	$20/$50/$110	$20/$50/$110	Not Covered	$20/$50/$110	$25/$75/$165

Plan Designs November 1, 2017

TOWN OF NANTUCKET - NON MEDICARE ELIGIBLE PLAN OPTIONS					
Covered Services	Network Blue New England	Blue Care Elect Preferred (PPO) In-Network	Blue Care Elect Preferred (PPO) Out-Network	Master Medical	GIC Tufts Navigator (Approximated)
Deductible	$500 / $1,000	$500 /$1,000	In/Out Network Combined	$500 / $1,000	$500/$1,000
Coinsurance	100%	100%	80%	100%	100%
Out of Pocket Maximum	$2,000/$4,000 Med. $1,000/$2,000 RX	$2,000/$4,000 Med $1,000/$2,000 RX	$3,000/Mbr None	$5,000/$10,000 Med $1,000/$2,000 RX	$5,000/$10,000
Preventative Care					
Well-Child Care Visits	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Routine adult exams, including tests	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Routine GYN exams, including tests	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Routine hearing exams	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Routine Vision exams	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Family planning services-office visits	Nothing	Nothing	Deductible & Coinsurance	Nothing, no deductible	Nothing
Outpatient Care					
Emergency Room visits	$25 per visit waived if admitted	$25 per visit waived if admitted		$25, no deductible waived if admitted	$100 per visit, after deductible waived if admitted
Office Visits					
PCP, OB/GYN	$20	$20	Deductible & Coinsurance	20% coinsurance after deductible	$10/$20/$40
Other network providers	$60	$60	Deductible & Coinsurance	20% coinsurance after deductible	$30/$60/$90
Chiropractor Office visits	$20	$20	Deductible & Coinsurance	20% coinsurance after deductible	$20
Mental Health or Substance Abuse	$10	$10	Deductible & Coinsurance	**20% coinsurance**	$20
Rehabilitation Therapy-Phys. & Occ.	$20	$20	Deductible & Coinsurance	20% coinsurance after deductible	$10
Speech, Hearing & language disorder	$20	$20	Deductible & Coinsurance	20% coinsurance after deductible	$20
DXL, and lab. Tests	Covered in Full after Ded.	Covered in Full after Ded.	Deductible & Coinsurance	Covered in full after deductible	Covered in Full, after deductible
Diagnostic Imaging & Nuclear Imag.	$100 after Deductible	$100 after Deductible	Deductible & Coinsurance	**$100**	$100 after deductible
Home Health Care & Hospice	Covered in Full after Ded.	CIF after Ded.	Deductible & Coinsurance	**20% HHC; Hospice covered in full**	Covered in Full, after deductible
Oxygen & Equipment	Nothing	Nothing	Deductible & Coinsurance	20% coinsurance after deductible	Covered in Full, after deductible
Durable Medical Equipment	20% after Deductible	20% after Deductible	Not Covered	20% coinsurance after deductible	Covered in Full, after deductible
Prosthetic Devices	20% after Deductible	20% after Deductible	Not Covered	20% coinsurance after deductible	Covered in Full, after deductible
Surgery by: PCP or OB/GYN	$20	$20	Deductible & Coinsurance	**Covered in full**	$10/$20/$40
Other network providers	$60	$60	Deductible & Coinsurance	**Covered in full**	$30/$60/$90
Ambulatory surgical/Outpatient facility	$250 after Deductible	$250 after Deductible	Deductible & Coinsurance	**$250**	$250, after deductible
Inpatient Care					
General or Chronic Hospital	$300/$1,300 after Ded.	$300/$1,300 after Ded.	Deductible & Coinsurance	**$500**	$275/$500/$1,500 per adm.
Mental or Substance Abuse Facility	$300/$1,300 after Ded.	$300/$1,300 after Ded.	Deductible & Coinsurance	**$500**	$200, quarterly
Rehabilitation Hospital	Covered in Full after Ded.	Covered in Full after Ded.	Deductible & Coinsurance	**$500**	Covered in Full, after deductible
Skilled Nursing Facility (100 days)	Covered in Full after Ded.	Covered in Full after Ded.	Deductible & Coinsurance	**Covered in Full**	Covered in Full, after deductible
Prescription Drug Coverage					
Plan Year Deductible	$100/$200	$100/$200	None	$100/$200	$100/$200
Retail - 30 day supply	$10/$30/$65	$10/$30/$65	Not Covered	$10/$30/$65	$10/$30/$65
Mail Order - 90 day supply	$25/$75/$165	$25/$75/$165	Not Covered	$25/$75/$165	$25/$75/$165