FOR COMMONWEALTH OF MASSACHUSETTS

MUNICIPAL

EMPLOYEES, RETIREES & SURVIVORS

Benefits and Rates Effective July 1, 2014

2014-2015 GIC BENEFIT DECISION GUIDE

ANNUAL ENROLLMENT April 9 - May 7, 2014

Evaluate Your Options Carefully!

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

OFFICE OF THE GOVERNOR
COMMONWEALTH OF MASSACHUSETTS
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DEVAL L. PATRICK
GOVERNOR

Spring 2014

Dear Colleagues:

As I said in my State of the Commonwealth speech in January, I am proud of the work that we in Massachusetts have done to improve health care for all of our residents. It is because of this hard work that our employees, our retirees and all those individuals who, because of the achievements of health care reform, now have health insurance to protect them and their families. It is a legacy I am proud of and I hope you share in that pride.

The Group Insurance Commission's Centered Care Initiative is a true commitment toward reducing health care costs and improving quality, not just maintaining it. The GIC's health plans will be reaching out to you to encourage your support for integrated delivery systems that will bring you care that is centered on you and your family. The focal point of this initiative is your Primary Care Provider (PCP), be it a physician, nurse practitioner or physician assistant. Your PCP will help coordinate the disparate services that modern medicine now provides through a team of providers offering different skills to meet your needs.

Getting the most out of this complex system depends on your active participation as a patient, a consistent relationship with a PCP and the coordination of care. Be sure to read through this 2014-2015 Benefit Decision Guide to get an overview of this initiative and your benefit options. You can also take advantage of other GIC resources for selecting your health plan, including the GIC's website, www.mass.gov/gic, and health fairs across the state.

I urge you to be at the center of your care coordination by choosing a PCP and playing an active role in improving your own health. Thank you for your service and for helping us move forward with health care improvements.

Sincerely,

HOW TO USE THIS GUIDE

All members should read:

Find out about your Employee/ Non-Medicare health plan options:

Find out about your Medicare health plan options:

Find out about other benefit options:

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

The *Benefit Decision Guide* is an overview of GIC benefits and is not a benefit handbook. Contact the plans or visit the GIC's website for more detailed plan handbooks.

Resources for additional information:

IMPORTANT REMINDERS

- This ***Benefit Decision Guide*** contains important benefit and rate changes effective July 1, 2014. Review pages 4-5, and 14 for details.
- Read the ***Annual Enrollment Checklist*** on page 2 for information to consider when selecting a health plan.
- Read the Employee/Non-Medicare ***Limited Network Plans – Great Value; Quality Coverage*** section on page 8 to find out more about limited network plan options for Employees and Non-Medicare Retirees/Survivors.
- If you want to ***keep your current GIC health plan***, you do not need to fill out any paperwork. Your coverage will continue automatically.
- **Once you choose a health plan, you cannot change plans *until the next annual enrollment***, even if your doctor or hospital leaves the health plan, unless you have a qualifying event, such as moving out of the plan's service area or retirees/survivors becoming Medicare eligible (in which case, you ***must*** enroll in a Medicare plan).
- Your annual enrollment forms or requests are due **no later than Wednesday, May 7, 2014**. Forms and applications are available on the GIC's website (www.mass.gov/gic/forms). Changes go into effect July 1, 2014:
  - **Active employees and New GIC Enrollees:** GIC enrollment forms and, if not already enrolled in a GIC plan, required documentation as outlined on the *Forms* section of our website to the GIC Coordinator in your benefits office.
  - **Existing Municipal Retirees/Survivors:** For health plan changes, municipal enrollment/change form or written request to the GIC. Retiree Dental form to the GIC Coordinator in your benefits office.

STEP 1: **IDENTIFY which health plan(s) you are eligible to join:**

- If you are retired, determine if you are eligible for Medicare *(see page 11)*.
- Where you live determines which plan(s) you may enroll in. *See the map on page 9 for Employee/Non-Medicare health plan locations and page 13 for Medicare plan locations.*
- See each health plan page for eligibility details *(see pages 16-32)*.

Do Your Homework During Annual Enrollment – Even If You Want to Stay in the Same Health Plan

STEP 2: **For the plans you are eligible to join and are interested in. . .**

- **REVIEW** their benefit summaries *(see pages 16-32)*.
- **WEIGH** features that are important to you, such as out-of-network benefits, prescription drug coverage, and mental health benefits.
- **REVIEW** their monthly rates *(see separate rate chart)*.
- **CONSIDER** enrolling in a limited network plan if you are an employee or Non-Medicare retiree/survivor – you will save money on your monthly premium *(see page 8)*.
- **CONTACT** the plan to find out about benefits that are not described in this guide.

STEP 3: **Find out if your doctors and hospitals are in the plan's network.** Call the plan or visit the plan's website and search for your own ***and*** your covered family members' doctors and hospitals. Be sure to specify the health plan's full name, such as "Harvard Pilgrim Primary *Choice Plan*" or "Harvard Pilgrim *Independence Plan*," not just "Harvard Pilgrim."

Your health plan selection is binding until the next annual enrollment, even if your doctor or hospital leaves your health plan's network during the year. The health plan will help you find another provider.

STEP 4: **Check on copay tier assignments** that affect what you pay when you get physician or hospital services. Copay tiers do not apply to the GIC Medicare plans.

Physician and hospital copay tiers can change each July 1 for GIC Employee and Non-Medicare Retiree/Survivor plans. During annual enrollment, check to see if your doctor's or hospital's tier has changed.

THREE GREAT RESOURCES

1. **The plan's website:** Get additional benefit details, information about network physicians, tools to make health care decisions and more. *See page 36 for website addresses.*
2. **The health plan's customer service line:** A representative can help you. *See page 36 for phone numbers.*
3. **A GIC Health Fair:** Talk with plan representatives and get personalized information and answers to your questions. *See page 35 for the health fair schedule.*

NEW HIRE AND ANNUAL ENROLLMENT OVERVIEW

Annual enrollment gives you the opportunity to review your benefit options and enroll in a health plan or make changes if you desire.

If you are a current municipal enrollee and want to keep the same GIC health plan, you do NOT need to fill out any paperwork. Your coverage will continue automatically.

NEW EMPLOYEES

Within 10 Calendar Days of Hire
GIC benefits begin on the first of the month following 60 days or two full calendar months, whichever comes first.

You may enroll in…
One of these health plans:

- Fallon Health Direct Care ✓
- Fallon Health Select Care
- Harvard Pilgrim Independence Plan
- Harvard Pilgrim Primary Choice Plan ✓
- Health New England ✓
- NHP Care (Neighborhood Health Plan) ✓
- Tufts Health Plan Navigator
- Tufts Health Plan Spirit ✓
- UniCare State Indemnity Plan/Basic
- UniCare State Indemnity Plan/Community Choice ✓
- UniCare State Indemnity Plan/PLUS

By submitting within 10 days of employment…

- GIC enrollment forms; and
- Required documentation for family coverage *(if applicable)* as outlined on the *Forms* section of our website to the GIC Coordinator in your benefits office

NOTE: Current employees who lose health insurance coverage elsewhere may enroll in GIC health coverage during the year with proof of involuntary loss of coverage. See your municipality's GIC Coordinator for details.

Once you choose a health plan, you cannot change plans until the next annual enrollment, even if your doctor or hospital leaves the health plan, unless you have a qualifying event, such as moving out of the plan's service area or are retired and become eligible for Medicare (in which case, you must enroll in a Medicare plan).

✓ Indicates a GIC Limited Network Plan.

* See page 33 for eligibility details.

EMPLOYEES AND *NON-MEDICARE* RETIREES/SURVIVORS

MEDICARE RETIREES/SURVIVORS

During annual enrollment
April 9-May 7, 2014
for changes effective July 1, 2014

You may enroll in or change your selection of one of these health plans:

- Fallon Senior Plan
- Harvard Pilgrim Medicare Enhance
- Health New England MedPlus
- Tufts Health Plan Medicare Complement
- Tufts Health Plan Medicare Preferred
- UniCare State Indemnity Plan/Medicare Extension (OME)

You may enroll in…

Retiree Dental Plan*

By submitting by May 7…

New GIC Enrollees and Active Employees:
GIC enrollment forms and, if not already enrolled in a GIC plan, required documentation as outlined on the *Forms* section of our website, to the GIC Coordinator in your benefits office

Existing Municipal Retirees/ Survivors:
Medicare or Non-Medicare enrollment/change form or written request asking for the change to the GIC

Retiree Dental Form to the GIC Coordinator in your benefits office

New Municipal Retirees/Survivors:
GIC Municipality Enrollment Forms, Retiree Dental Form, and required documentation as outlined on the *Forms* section of our website to the GIC Coordinator in your benefits office

Existing Municipal Retirees/ Survivors:
Medicare or Non-Medicare enrollment/change form or written request asking for the change to the GIC

Retiree Dental Form to the GIC Coordinator in your benefits office

- Enrollment and application forms are available on our website – **www.mass.gov/gic/forms** – and through the GIC Coordinator in your benefits office.
- Current Retirees/Survivors: for written requests to make a health plan change, include your name, address and GIC identification number.

The Centered Care Initiative seeks to improve health care coordination and quality while reducing costs. Primary Care Providers play a critical role in helping their patients get the right care at the right place with the right provider. The central idea is to coordinate health care services around the needs of you, the patient. Because health care is so expensive, Centered Care also seeks to engage providers and health plans in managing these dollars more efficiently.

These efforts to manage spending benefit both you and Commonwealth taxpayers. Not only have we ***avoided cutting benefits***, we were able to ***add*** federal-mandated benefits and some modest benefit enhancements, while also achieving an ***overall 1.0% premium increase*** for all employee and Medicare plans for the Fiscal Year 2015, the lowest increase in over 10 years. These rates are lower than national employer trends, which, according to *Mercer's National Survey of Employer-Sponsored Health Plans*, will increase 2.1% in 2014 and another 5.2% in 2015. Other employers are controlling costs through enrollment restrictions and benefit cuts. The GIC's Centered Care program holds our health plans to lower costs and improved health care over a five-year period.

In addition to helping to keep premiums in check, how does this affect EMPLOYEES AND NON-MEDICARE members?

THERE ARE 10 KEY ELEMENTS OF CENTERED CARE:

centered care

1. **Primary Care Provider (PCP) designation** – your health plan keeps track of who your PCP is and lets the provider know that you are their patient and you have selected him or her to coordinate your care.
2. **PCP engagement** – your PCP helps coordinate your care.
3. **Data sharing** – electronic medical records provide secure access to your health history, prescriptions, lab results and appointments to help your PCP and other providers keep track of your medical needs and make sure they are met.
4. **Low-cost providers are encouraged** – you will continue to have incentives for choosing low-cost, high-quality specialists and hospitals.
5. **Expanded hours and urgent care access** – the GIC and our health plans are working to expand providers' hours to include some evenings and weekend appointments, making it more convenient for members with off-hour urgent care needs.
6. **High level of care for chronically ill** – if you have a chronic condition, your PCP will monitor and advise you all year long.
7. **Disease management** – members' health plans will identify patients at risk for complications and will help those members and their PCPs navigate their care and find out about best practices.
8. **Group visits** – patients with similar conditions sometimes meet together with providers for education, group interaction, support, self-management assistance, and direct patient-practitioner encounters. These types of visits include wellness programs for patients with weight-related issues, diabetes, or low back pain.
9. **Transitional care management** – when you are released from the hospital to rehab or home, your treatment plan accompanies you.
10. **Essential reporting package** – our health plans will help providers to help you by giving them timely reports on patients, their fellow physicians, and best practices.

Benefits of all *Employee/Non-Medicare* health plans help support this initiative:

- All plans will be reaching out to members to acquire PCP information.
- One plan will offer a copay incentive for visiting a Centered Care PCP.
- Health plans will continue to tier specialists based on quality and/or cost-efficiency scores. Millions of physician claims are analyzed for differences in how physicians perform on nationally recognized measures of quality and/or cost efficiency.

You pay the lowest copay for the highest-performing doctors:

★★★ Tier 1 (excellent)
★★ Tier 2 (good)
★ Tier 3 (standard)

Physicians for whom there is not enough data and non-tiered specialists are assigned a plan's Tier 2 copay.

During annual enrollment, check your doctors' and hospitals' tier, as they can change each July 1 with new data.

ALL EMPLOYEE AND NON-MEDICARE HEALTH PLANS

Benefit Changes Related to Federal Health Care Reform and Mental Health Parity

Increased coverage for the following benefits; these benefits will be standardized across all **Employee/Non-Medicare** health plans:

- **No dollar limit on wigs** needed for cancer, leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury; restrictions may apply
- **No dollar limit on low-protein foods** for specified complex medical conditions
- **No dollar limit on medically necessary Early Intervention Services** (infant to age 3)
- **No dollar limit on in-home dialysis** supplies, drugs and equipment
- **No dollar limit on speech therapy:** visit maximums apply
- **$5,000 per person/$10,000 per family in-network out-of-pocket maximum:** out-of-pocket maximum will apply to medical and mental health/substance abuse costs, but will not apply to prescription drug costs for Harvard Independence and Primary Choice, Tufts Navigator and Spirit, and UniCare Basic, Community Choice and PLUS. Out-of-pocket maximum will apply to medical, mental health/substance abuse, and prescription drug costs for Fallon Direct and Select Care, Health New England and Neighborhood Health Plan.

There are no benefit changes for MEDICARE plans.

OTHER EMPLOYEE/NON-MEDICARE HEALTH PLAN BENEFIT CHANGES

FALLON HEALTH DIRECT CARE AND SELECT CARE

ItFits Health Club Reimbursement Benefit expanded to include one three-month gym membership reimbursement per subscriber to YMCA/YWCA; one five-month Weight Watchers Monthly Pass reimbursement per subscriber.

NEIGHBORHOOD HEALTH PLAN

PCP Copay: In keeping with the GIC's efforts to encourage care coordination by Primary Care Providers (PCPs), PCPs will no longer be tiered and the copay will be $20 per visit.

Outpatient Mental Health/Substance Abuse Copay: $20 per visit

TUFTS HEALTH PLAN NAVIGATOR AND SPIRIT

Inpatient Hospital Care: Tufts Health Plan will no longer tier hospitals by different types of services. Hospitals will be tiered for all services combined based on quality and/or cost.

UNICARE INDEMNITY PLAN BASIC, COMMUNITY CHOICE, AND PLUS

Certain Oral, Injectable, Infused and Inhaled Specialty Drugs for conditions such as arthritis, multiple sclerosis and immune diseases will only be dispensed and covered through CVS Caremark Specialty Pharmacy and will be excluded from the medical benefit. This provision does not apply to infused chemotherapy agents.

UNICARE INDEMNITY PLAN PLUS

PCP Copay: Members will pay a lower copay if they visit a Centered Care PCP: $15 per visit

Municipal News

The **Towns of East Bridgewater, Framingham and Middleborough** will join GIC health benefits effective July 1, 2014.

The **Town of North Andover** will be offering the GIC Retiree Dental Plan. During the Spring Open Enrollment, eligible retirees and survivors from North Andover and 12 other participating municipalities may join the plan for coverage effective July 1, 2014. *See page 33 for details.*

How Status Changes Affect GIC Benefits

Q ***As a new employee, when do my GIC benefits begin?***

A GIC benefits begin on the first day of the month following 60 days or two full calendar months of employment, whichever comes first.

Q ***I am an active GIC-eligible employee. I am also retired from a state agency or participating municipality and eligible for GIC retirement benefits. Can I choose both employee and retiree benefits?***

A No. You must choose either active employee ***or*** retiree benefits. Contact the GIC to indicate whether you want employee or retiree benefits.

Q ***I'm turning age 65; what do I need to do?***

A If you are age 65 or over, call or visit your local Social Security Office for confirmation of Social Security and Medicare benefit eligibility. **If you are eligible for Medicare Part A for free and if you are retired from a GIC participating municipality, you must enroll in Medicare Parts A and B** to continue coverage with the GIC.

If you are eligible for Medicare Part A for free and continue working for a GIC participating municipality after age 65, you should ***not*** enroll in Medicare Part B until you (the insured) retire.

A spouse who is 65 or over, and who is covered by an active employee, should ***not*** sign up for Medicare Part B until the insured retires.

Most enrollees should not sign up for Medicare Part D. Your drugs are already provided by your health plan.

Q ***I am retired from a GIC participating municipality, but not yet age 65. My GIC-covered spouse is turning age 65. What does my covered spouse need to do?***

A If your GIC-covered spouse turns age 65 before you (the insured GIC retiree), your covered spouse should visit your local Social Security Office for confirmation of Social Security and Medicare benefit eligibility. **If your covered spouse is eligible for Part A for free, he/she must enroll in Medicare Parts A and B to continue coverage with the GIC.**

Q ***I am retired from a participating municipality. I am (or my covered spouse is) age 65 or over and the other one of us is not. How does this affect our GIC health insurance?***

A If you or your covered spouse is age 65 or over and eligible for Medicare Part A for free, but the other one is under age 65, the person under age 65 will continue to be covered under a Non-Medicare plan until he/she becomes eligible for Medicare coverage. The person age 65 or over must enroll in a GIC Medicare Plan. If you have Medicare/Non-Medicare combination coverage, you must enroll in one of the pairs of plans listed on page 11.

Q ***My full-time student goes to school outside of our health plan's service area. May we remain in our current health plan?***

A Yes. Your family may remain in your current health plan for as long as your child is a full-time student and enrolled in GIC coverage as a full-time student.

However, if your child age 19 to 26 ceases to be a full-time student, complete and return the *Dependent Age 19 to 26 Enrollment and Change Form*; that child must reside within your health plan's service area to be covered. If he or she lives outside of your health plan's service area, the family must be enrolled in the UniCare Indemnity Plan/Basic.

Q ***If I die, is my surviving spouse eligible for GIC health insurance?***

A If you (the insured) have coverage through the GIC at the time of your death, your surviving spouse is eligible for GIC health insurance coverage ***until he/she remarries or dies***. However, he/she must apply for survivor coverage by contacting the GIC for an application; survivor coverage is ***not*** an automatic benefit. If your surviving spouse is a participating municipal or state employee or retiree, he or she must elect coverage through the participating municipality or state and is not eligible for survivor health coverage.

You MUST Notify Your Benefits Office *(active employees)* or the GIC *(retirees and survivors)* When Your Personal or Family Information Changes

Failure to provide timely notification of personal information changes may affect your insurance coverage and may result in your being billed for services provided to you or a family member. If any of the following occur, active employees must notify the GIC Coordinator in their benefits office; if you are a retiree or survivor, write to the GIC:

- Marriage or remarriage
- Remarriage of a former spouse
- Legal separation
- Divorce
- Address change
- Dependent age 19 to 26 who is no longer a full-time student
- Dependent other than full-time student who has moved out of your health plan's service area
- Death of an insured
- Death of a covered spouse or dependent
- Birth or adoption of a child
- Legal guardianship of a child
- You have GIC COBRA coverage and become eligible for other health coverage

You may be held personally and financially responsible for failure to notify the GIC of personal or family status changes.

See the GIC's website for answers to other frequently asked questions: www.mass.gov/gic/faq

Employees and Non-Medicare Retirees and Survivors: Consider Enrolling in a Limited Network Plan to Save Money Every Month on Your Premiums!

Limited network plans help address differences in provider costs. You will enjoy similar benefits to wider network plans, but will save money because limited network plans have a smaller network of providers (fewer doctors and hospitals). Your savings depend on:

- The plan you are switching from,
- The plan you select,
- Your premium percentage contribution, and
- Whether you have individual or family coverage.

See the separate municipal rate chart to calculate your savings.

Find out if your hospital is in a GIC limited network plan

The GIC has a side-by-side comparison of the six limited network plans and their participating hospitals on our website: **www.mass.gov/gic/limitedplans**

For participating physician and other provider details, contact the individual plans by phone or visit their website *(see page 36)*.

Your Responsibility Before You Enroll in a Plan

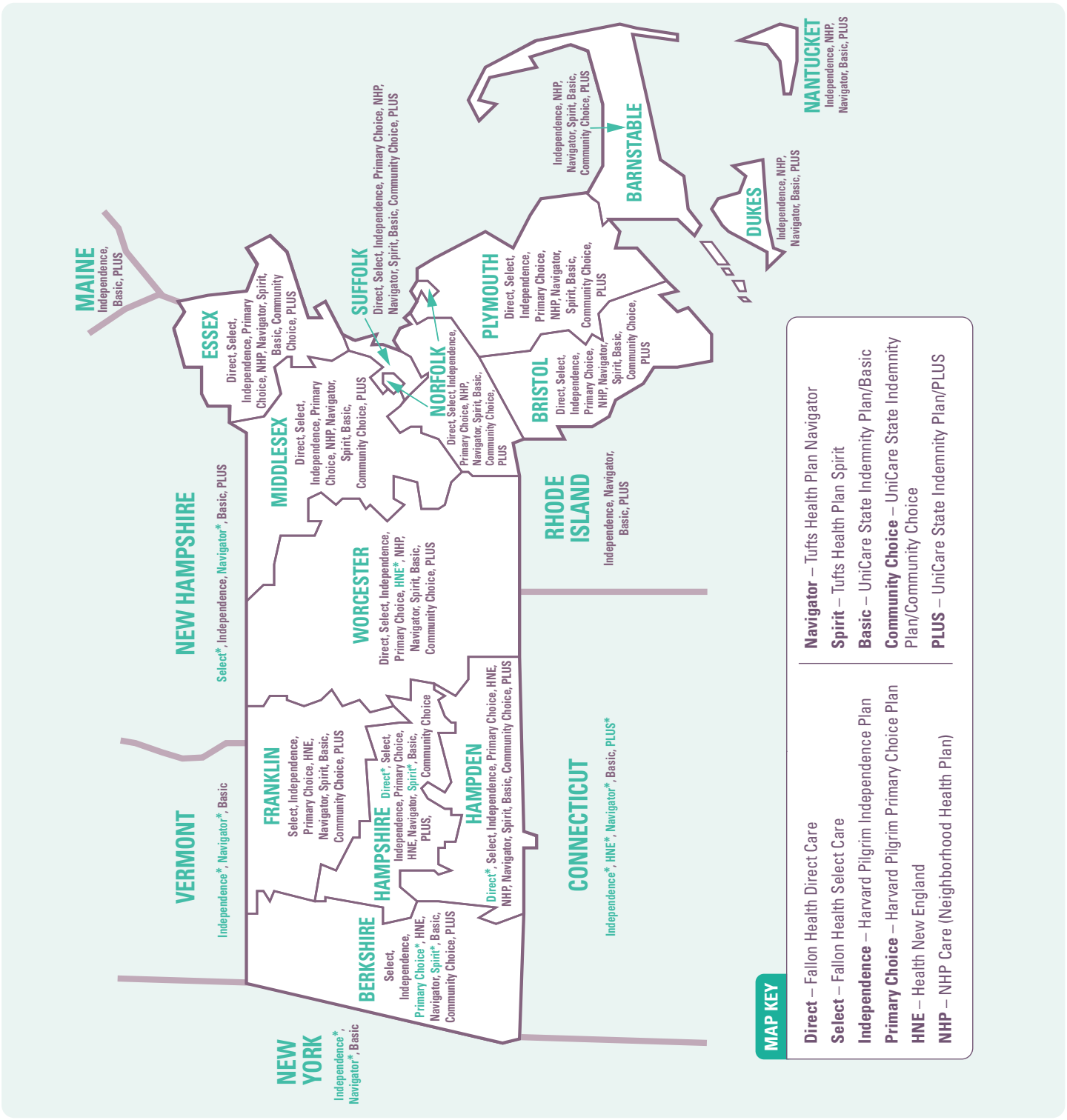
- ***Once you choose a plan, you cannot change health plans during the year,*** unless you move out of the plan's service area or within 30 days of certain qualifying events. If your doctor or hospital leaves your health plan, you must find a new participating provider in your chosen plan.
- Check if your doctors participate in the plan
- Find out if the doctors' affiliated hospitals are in the plan
- **Keep in Mind:** Doctors and hospitals can leave a plan during the year, usually because of health plan and provider contract issues, practice mergers, retirement or relocation.

GREAT VALUE. QUALITY COVERAGE. Limited Network Plan

The GIC's limited network plans are:

- **Fallon Health Direct Care** – an HMO available throughout central Massachusetts, Metro West, Middlesex County, the North Shore and the South Shore. The plan includes 26 area hospitals and another five "Peace of Mind" hospitals in Boston that provide second opinions and care for very complex cases.
- **Harvard Pilgrim Primary Choice Plan** – an HMO with a network of 55 hospitals. The plan is available throughout Massachusetts, except for Cape Cod, Martha's Vineyard, Nantucket, and parts of Berkshire County.
- **Health New England** – a western Massachusetts-based HMO that also covers parts of Worcester County and includes 18 Massachusetts hospitals.
- **NHP Care (Neighborhood Health Plan)** – an HMO with a provider network that includes community health centers, independent medical groups and hospital group practices, as well as 57 hospitals. NHP Care is available across most of the state except for Berkshire, Franklin, and Hampshire Counties.
- **Tufts Health Plan Spirit** – an EPO (HMO-type) plan with a network of 53 hospitals. The plan is available throughout Massachusetts, except for Martha's Vineyard, Nantucket and parts of Berkshire and Hampshire Counties.
- **UniCare State Indemnity Plan/Community Choice** – a PPO-type plan with a network of 53 hospitals. All Massachusetts physicians participate. The plan is available throughout Massachusetts, except for Martha's Vineyard and Nantucket.

Where You Live Determines Which Plan You May Enroll In.
Is the *NON-MEDICARE* Health Plan Available Where You Live?



The UniCare State Indemnity Plan/Basic is the only *Employee/Non-Medicare* plan offered by the GIC that is available throughout the United States and outside of the country.

***** Not every city and town is covered in this county or state; contact the plan to find out if you live in the service area. The plan also has a limited network in this county or state; contact the plan to find out which doctors and hospitals participate in the plan.

Deductible Questions and Answers

Q ***What is a deductible?***

A All GIC **Employee and Non-Medicare retiree/survivor health plans** include a calendar year deductible. This is a fixed dollar amount you must pay each calendar year before your health plan begins paying benefits for you or your covered dependent(s). This is a separate charge from any copays.

Q ***How much is the in-network calendar year deductible?***

A The deductible is $250 per member, up to a maximum of $750 per family.

Here is how it works for each coverage level:

- **Individual:** The individual has a $250 deductible before benefits begin.
- **Two-person family:** Each person must satisfy a $250 deductible.
- **Three- or more person family:** The maximum each person must satisfy is $250 until the family as a whole reaches the $750 maximum.

If you are in a PPO-type plan, the out-of-network deductible is $400 per member, up to a maximum of $800 per family; this is a separate charge from the in-network deductible.

Q ***If I change health plans, am I subject to another deductible?***

A Although GIC health benefits are effective each July, the deductible is a calendar year cost.

You <u>will not</u> be subject to a new deductible if:

You stay with the same health plan carrier but switch to one of its other options.

You <u>will</u> be subject to a new deductible if:

You choose a new GIC health plan carrier.

Q ***Which health care services are subject to the deductible?***

A The lists below summarize expenses that generally are and are not subject to the annual deductible. These are not exhaustive lists. You should check with your health plan for details. As with all benefits, ***variations in these guidelines below may occur, depending upon individual patient circumstances and a plan's schedule of benefits.***

Examples of in-network expenses ***generally exempt*** from the deductible:

- Prescription drug benefits
- Outpatient mental health/substance abuse benefits
- Office visits (primary care physician, specialist, retail clinics, preventive care, maternity and well baby care, routine eye exam, occupational therapy, physical therapy, chiropractic care and speech therapy)
- Medically necessary child and adult immunizations
- Medically necessary wigs
- Hearing aids
- Mammograms
- Pap smears
- EKGs

Examples of in-network expenses ***generally subject to*** the deductible:

- Emergency room visits
- Inpatient hospitalization
- Surgery
- Laboratory and blood tests
- X-rays and radiology (including high-tech imaging such as MRI, PET and CT scans)
- Durable medical equipment

Q ***How will I know how much I need to pay out of pocket?***

A Upon request, plans are now required to tell you before you incur a cost the amount you will be required to pay. Call your plan or visit their website to get this information.

When you visit a doctor or hospital, the provider will ask you for your copay upfront. After you receive services, your health plan may provide you with an Explanation of Benefits, or you can call your plan to find out which portion of the costs you will be responsible for. The provider will then bill you for any balance owed.

Medicare Guidelines

Medicare is a federal health insurance program for retirees age 65 or older and certain disabled people. Medicare Part A covers inpatient hospital care, some skilled nursing facility care and hospice care. Medicare Part B covers physician care, diagnostic x-rays and lab tests, and durable medical equipment. Medicare Part D is a federal prescription drug program.

When you or your spouse is age 65 or over, or if you or your spouse is disabled, visit your local Social Security Administration office to find out if you are eligible for free Medicare Part A coverage.

If you (the insured) continue working after age 65, you and/or your spouse should NOT enroll in Medicare Part B until you (the insured) retire.

When you (the insured) retire:

- If you and/or your spouse is eligible for free Medicare Part A coverage, state law requires that you and/or your spouse enroll in Medicare Part A and Part B in order to be covered by the GIC.
- You must join a Medicare plan sponsored by the GIC to continue health coverage. These plans provide comprehensive coverage for some services that Medicare does not cover. If both you and your spouse are Medicare eligible, both of you must enroll in the same Medicare plan.
- You MUST continue to pay your Medicare Part B premium. Failure to pay this premium will result in the loss of your GIC coverage.

Retiree and Spouse Coverage if Under and Over Age 65

If you (the retiree), your spouse or other covered dependent is younger than age 65, the person or people under age 65 will continue to be covered under a Non-Medicare plan until you and/or he/she becomes eligible for Medicare.

If this is the case, you must enroll in one of the pairs of plans listed below:

Health Plan Combination Choices

NON-MEDICARE PLAN	MEDICARE PLAN
Fallon Health Direct Care	Fallon Senior Plan
Fallon Health Select Care	Fallon Senior Plan
Harvard Pilgrim Independence Plan	Harvard Pilgrim Medicare Enhance
Harvard Pilgrim Primary Choice Plan	Harvard Pilgrim Medicare Enhance
Health New England	Health New England MedPlus
Tufts Health Plan Navigator	Tufts Health Plan Medicare Complement
Tufts Health Plan Navigator	Tufts Health Plan Medicare Preferred
Tufts Health Plan Spirit	Tufts Health Plan Medicare Complement
Tufts Health Plan Spirit	Tufts Health Plan Medicare Preferred
UniCare State Indemnity Plan/Basic	UniCare State Indemnity Plan/ Medicare Extension (OME)
UniCare State Indemnity Plan/Community Choice	UniCare State Indemnity Plan/ Medicare Extension (OME)
UniCare State Indemnity Plan/PLUS	UniCare State Indemnity Plan/ Medicare Extension (OME)

How to Calculate Your Rate

See separate rate chart from your municipality.

Retiree and Spouse Both on Medicare

Find the premium for the Medicare plan in which you are enrolling and double it for your total monthly rate.

Retiree and Spouse Coverage if Under and Over Age 65

1. Find the premium for the Medicare Plan in which the Medicare retiree or spouse will be enrolling.
2. Find the individual coverage premium for the Non-Medicare Plan in which the Non-Medicare retiree or spouse will be enrolling.
3. Add the two premiums together; this is the total that you will pay monthly.

Helpful Reminders

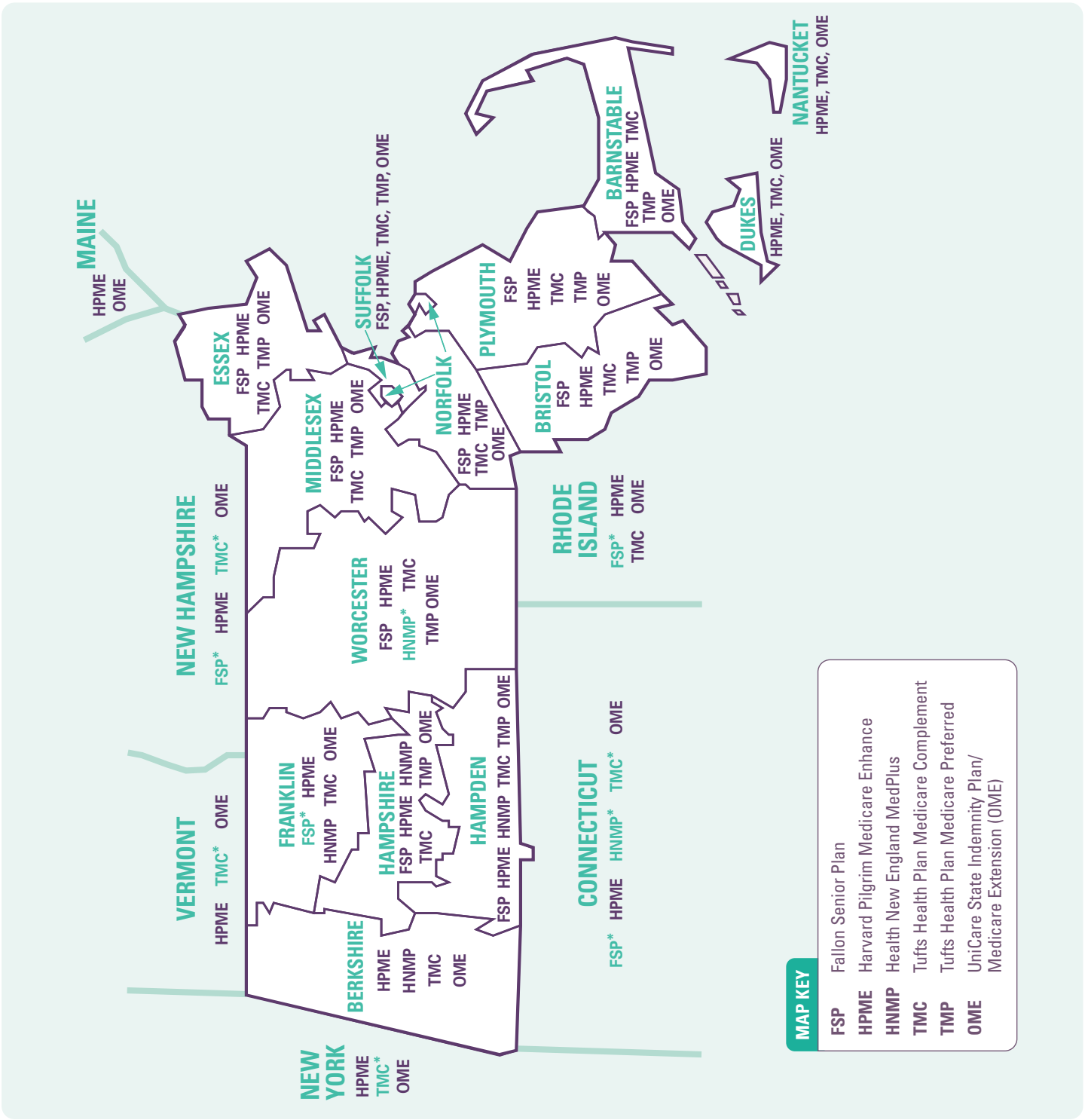
- Call or visit your local Social Security office for more information about Medicare benefits.
- HMO Medicare plans require you to live in their service area. *See the map on page 13.*
- You may change GIC Medicare plans only during annual enrollment, unless you have a qualifying event, such as moving out of your plan's service area. Note: Even if your doctor or hospital drops out of your Medicare HMO, you must stay in the HMO until the next annual enrollment. Your Medicare HMO will help you find another provider.
- Benefits and rates of Fallon Senior Plan and Tufts Health Plan Medicare Preferred are subject to federal approval and may change January 1, 2015; you cannot change plans until the Spring Annual Enrollment period. These plans automatically include Medicare Part D prescription drug benefits. Contact the plans for additional details.

Important Information About Medicare Part D

Medicare Retirees and Survivors

For most GIC Medicare enrollees, the drug coverage you currently have through your GIC health plan has better benefits than the federal Medicare Part D drug plan options. Therefore, you do not need to enroll in a Medicare Part D drug plan. *See page 15 for additional details.*

Where You Live Determines Which Plan You May Enroll In. Is the *MEDICARE* Health Plan Available Where You Live?



The Harvard Pilgrim Medicare Enhance Plan is available throughout the United States. The UniCare State Indemnity Plan/Medicare Extension is available throughout the United States and outside of the country.

* Not every city and town is covered in this county or state; contact the plan to find out if you live in the service area. The plan also has a limited network in this county or state; contact the plan to find out which doctors and hospitals participate in the plan.

EFFECTIVE JULY 1, 2014

Full Cost Rates Including the 0.40% Administrative Fee

For the rate you will pay as a municipal employee or retiree/survivor, see separate rate chart from your municipality.

Employee and Non-Medicare Retiree/Survivor Health Plans

HEALTH PLAN	PLAN TYPE	INDIVIDUAL	FAMILY
Fallon Health Direct Care ✓	HMO	$483.21	$1,159.70
Fallon Health Select Care	HMO	615.39	1,476.92
Harvard Pilgrim Independence Plan	PPO	686.12	1,674.20
Harvard Pilgrim Primary Choice Plan ✓	HMO	548.89	1,339.36
Health New England ✓	HMO	481.89	1,194.71
NHP Care (Neighborhood Health Plan) ✓	HMO	465.41	1,233.34
Tufts Health Plan Navigator	PPO	619.87	1,497.60
Tufts Health Plan Spirit ✓	HMO-type	500.37	1,206.01
UniCare State Indemnity Plan/Basic *with CIC* (Comprehensive)	Indemnity	936.24	2,185.22
UniCare State Indemnity Plan/Basic *without CIC* (Non-Comprehensive)	Indemnity	893.83	2,086.85
UniCare State Indemnity Plan/Community Choice ✓	PPO-type	456.68	1,095.99
UniCare State Indemnity Plan/PLUS	PPO-type	656.90	1,567.69

Medicare Plans

HEALTH PLAN	PLAN TYPE	PER PERSON
Fallon Senior Plan*	Medicare (HMO)	$290.79
Harvard Pilgrim Medicare Enhance	Medicare (Indemnity)	394.79
Health New England MedPlus	Medicare (HMO)	363.13
Tufts Health Plan Medicare Complement	Medicare (HMO)	348.39
Tufts Health Plan Medicare Preferred*	Medicare (HMO)	266.56
UniCare State Indemnity Plan/Medicare Extension (OME) *with CIC* (Comprehensive)	Medicare (Indemnity)	379.45
UniCare State Indemnity Plan/Medicare Extension (OME) *without CIC* (Non-Comprehensive)	Medicare (Indemnity)	368.63

* Benefits and rates of Fallon Senior Plan and Tufts Health Plan Medicare Preferred are subject to federal approval and may change January 1, 2015.

Compare the rates of these plans with the other options and see how much you will save every month!

Drug Copayments

All GIC health plans provide benefits for prescription drugs using a three-tier copayment structure in which your copayments vary, depending on the drug dispensed. The following descriptions will help you understand your prescription drug copayment levels. Contact the plans you are considering with questions about your specific medications.

Tier 1: You pay the *lowest* copayment. This tier is primarily made up of generic drugs, although some brand name drugs may be included. Generic drugs have the same active ingredients in the same strength as their brand name counterparts. Brand name drugs are almost always significantly more expensive than generics.

Tier 2: You pay the *mid-level* copayment. This tier is primarily made up of brand name drugs, selected based on reviews of the relative safety, effectiveness and cost of the many brand name drugs on the market. Some generics may also be included.

Tier 3: You pay the *highest* copayment. This tier is primarily made up of brand name drugs not included in Tiers 1 or 2. Generic or brand name alternatives for Tier 3 drugs may be available in Tiers 1 or 2.

Tip for Reducing Your Prescription Drug Costs

Use Mail Order: Are you taking prescription drugs for a long-term condition, such as asthma, high blood pressure, allergies, or high cholesterol? Switch your prescription from a retail pharmacy to mail order. It can save you money – up to one copay every three months. *See pages 16-32 for copay details.* Once you begin mail order, you can conveniently order refills by phone or online. Contact your plan for details.

Prescription Drug Programs

Some GIC plans, including the UniCare State Indemnity Plans' prescription drug program managed by CVS Caremark, have the following programs to encourage the use of safe, effective and less costly prescription drugs. Contact the plans you are considering to find out details about these programs:

- **Mandatory Generics** – When filling a prescription for a brand name drug for which there is a generic equivalent, you will be responsible for the cost difference between the brand name drug and the generic, plus the generic copay.
- **Step Therapy** – This program requires enrollees to try effective, less costly drugs before more expensive alternatives will be covered.
- **Maintenance Drug Pharmacy Selection** – If you receive 30-day supplies of your maintenance drugs at a retail pharmacy, you must call your prescription drug plan to tell them whether or not you wish to change to 90-day supplies through either mail order or certain retail pharmacies.
- **Specialty Drug Pharmacies** – If you are prescribed specialty drugs—such as injectable drugs for conditions such as hepatitis C, rheumatoid arthritis, infertility, and multiple sclerosis—you'll need to use a specialized pharmacy which can provide you with 24-hour clinical support, education and side effect management. Medications are delivered to your home or to your doctor's office.

Medicare Part D Prescription Drug Reminders and Warnings

For most GIC Medicare enrollees, the drug coverage you currently have through your GIC health plan is a better value than the federal Medicare Part D drug plans being offered. Therefore, most individuals should ***not*** enroll in a federal Medicare drug plan.

- A "Notice of Creditable Coverage" is in your plan handbook. It provides proof that you have comparable or better coverage than Medicare Part D. If you should later enroll in a Medicare drug plan because of changed circumstances, you must show the Notice of Creditable Coverage to the Social Security Administration to avoid paying a penalty. Keep this notice with your important papers.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage; this may be the one instance where signing up for a Medicare Part D plan may work for you. Help is available online at **www.ssa.gov** or by phone at **1.800.772.1213**.
- If you are a member of one of our Medicare Advantage plans (Fallon Senior Plan and Tufts Health Plan Medicare Preferred), your plan automatically includes Medicare Part D coverage. If you enroll in another Medicare Part D drug plan, the Centers for Medicare & Medicaid Services will automatically dis-enroll you from your GIC Medicare Advantage health plan, which means you will **no longer have a Medicare plan through the GIC**.

FALLON HEALTH DIRECT CARE HMO

Fallon Health Direct Care is an HMO that provides coverage through the plan's network of doctors, hospitals and other providers. Members must select a Primary Care Provider (PCP) to manage their care and obtain referrals to specialists. The plan offers a selective network based in a geographically concentrated area.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency care.

Calendar Year Deductible

$250 per individual up to a maximum of $750 per family. *See page 10 for details.*

In-Network Out-of-Pocket Maximum

$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

Fallon Health Direct Care is available in the following Massachusetts counties:

Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, Worcester

Fallon Health Direct Care is available only in certain parts of the following Massachusetts counties; contact the plan to find out if you live in the service area:

Hampden, Hampshire

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

YOUR RESPONSIBILITY

Do your doctors and hospitals participate in Fallon Direct? Contact the plan.

Great Value Quality Coverage — Limited Network Plan

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Fallon Health
1.866.344.4442
www.fchp.org/gic

Copays Effective July 1, 2014

Primary Care Provider Office Visit
$15 per visit

Preventive Services
Most covered at 100% – no copay

Specialist Office Visit
$25 per visit

Outpatient Mental Health and Substance Abuse Care
$15 per visit

Retail Clinic
$15 per visit

Inpatient Hospital Care – Medical
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year):
$200 per admission

Outpatient Surgery
(Maximum four copays per person per calendar year):
$110 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans)*
(Maximum one copay per day):
$100 per scan

Emergency Room
$100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

FALLON HEALTH SELECT CARE HMO

Fallon Health Select Care is an HMO that provides coverage through the plan's network of doctors, hospitals, and other providers. Members must select a Primary Care Provider (PCP) to manage their care and obtain referrals to specialists.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency care.

Members pay lower copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see how your provider is rated. Members pay a lower inpatient hospital copay when they use Tier 1 or Tier 2 hospitals. Contact the plan to find out which tier your hospital is in.

Calendar Year Deductible
$250 per individual up to a maximum of $750 per family.
See page 10 for details.

In-Network Out-of-Pocket Maximum
$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

Fallon Health Select Care is available in the following Massachusetts counties:

Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester

Fallon Health Select Care is available only in certain parts of the following state; contact the plan to find out if you live in the service area:

New Hampshire

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

YOUR RESPONSIBILITY
Do your doctors and hospitals participate in Fallon Select? Contact the plan.

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Fallon Health
1.866.344.4442
www.fchp.org/gic

Copays Effective July 1, 2014

Primary Care Provider Office Visit: $20 per visit

Preventive Services: Most covered at 100% – no copay

Specialist Office Visit
Fallon Health tiers the following specialists based on quality and/or cost efficiency: Allergists/Immunologists, Cardiologists, Endocrinologists, Gastroenterologists, Hematologists/Oncologists, Nephrologists, Neurologists, Obstetricians/Gynecologists, Orthopedists, Otolaryngologists (ENTs), Podiatrists, Pulmonologists, Rheumatologists, and Urologists.

★★★	Tier 1 (excellent):	$25 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care
$20 per visit

Inpatient Hospital Care – Medical
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year):

Tier 1:	$250 per admission
Tier 2:	$500 per admission
Tier 3:	$750 per admission

Outpatient Surgery
(Maximum four copays per person per calendar year):
$125 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans)*
(Maximum one copay per day): $100 per scan

Emergency Room
$100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

HARVARD PILGRIM INDEPENDENCE PLAN PPO

The Harvard Pilgrim Independence Plan, administered by Harvard Pilgrim Health Care, is a PPO plan that offers coverage through network doctors, hospitals and other health care providers with a copay. Or, you may seek care from an out-of-network provider for 80% coverage of reasonable and customary charges. The plan encourages members to select a Primary Care Provider (PCP). Members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see if your provider is in the network and how he/she is rated.

The plan also tiers hospitals based on quality and/or cost; members pay a lower inpatient hospital copay when they use Tier 1 or Tier 2 hospitals. Contact the plan to see which tier your hospital is in.

Calendar Year Deductible

$250 per individual up to a maximum of $750 per family. *See page 10 for details.*

In-Network Out-of-Pocket Maximum – *Excludes Prescription Drug Costs*

$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

The Harvard Pilgrim Independence Plan is available throughout Massachusetts.

The plan is also available in the following other states:

Maine, New Hampshire, Rhode Island

The Harvard Pilgrim Independence Plan is available only in certain parts of the following states; contact the plan to find out if you live in the service area:

Connecticut, New York, Vermont

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Harvard Pilgrim Health Care
1.800.542.1499
www.harvardpilgrim.org/gic

In-Network Copays Effective July 1, 2014

Primary Care Provider Office Visit: $20 per visit

Preventive Services: Most covered at 100% – no copay

Specialist Office Visit
Harvard Pilgrim Health Care tiers the following Massachusetts specialists based on quality and/or cost efficiency: Allergists/ Immunologists, Cardiologists, Dermatologists, Endocrinologists, Gastroenterologists, General Surgeons, Neurologists, Obstetricians/Gynecologists, Ophthalmologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, and Rheumatologists.

★★★	Tier 1 (excellent):	$20 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care
$20 per individual visit

Inpatient Hospital Care – Medical
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year)
Harvard Pilgrim Health Care tiers its hospitals based on quality and/or cost:

Tier 1:	$250 per admission
Tier 2:	$500 per admission
Tier 3:	$750 per admission

Outpatient Surgery
(Maximum four copays per person per calendar year):
$150 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans)*
(Maximum one copay per day): $100 per scan

Emergency Room
$100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

HARVARD PILGRIM PRIMARY CHOICE PLAN HMO

The Harvard Pilgrim Primary Choice Plan, administered by Harvard Pilgrim Health Care, is an HMO plan that provides coverage through the plan's network of doctors, hospitals and other providers. Members must select a Primary Care Provider (PCP) to manage their care and obtain referrals to specialists.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency care.

Members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see if your provider is in the network and how he/she is rated. The plan also tiers hospitals based on quality and/or cost; members pay a lower inpatient hospital copay when they use Tier 1 hospitals. Contact the plan to see which tier your hospital is in.

Calendar Year Deductible

$250 per individual up to a maximum of $750 per family. *See page 10 for details.*

In-Network Out-of-Pocket Maximum – *Excludes Prescription Drug Costs*

$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

The Harvard Pilgrim Primary Choice Plan is available in the following Massachusetts counties:

Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester

The Harvard Pilgrim Primary Choice Plan is available only in certain parts of the following Massachusetts county; contact the plan to find out if you live in the service area:

Berkshire

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

YOUR RESPONSIBILITY

Do your doctors and hospitals participate in Harvard Pilgrim Primary Choice? Contact the plan.

GREAT VALUE QUALITY COVERAGE Limited ★★★ Network Plan

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Harvard Pilgrim Health Care
1.800.542.1499
www.harvardpilgrim.org/gic

Copays Effective July 1, 2014

Primary Care Provider Office Visit: $20 per visit

Preventive Services: Most covered at 100% – no copay

Specialist Office Visit

Harvard Pilgrim Health Care tiers the following Massachusetts specialists based on quality and/or cost efficiency: Allergists/Immunologists, Cardiologists, Dermatologists, Endocrinologists, Gastroenterologists, General Surgeons, Neurologists, Obstetricians/Gynecologists, Ophthalmologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, and Rheumatologists.

★★★	Tier 1 (excellent):	$20 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care

$20 per individual visit

Inpatient Hospital Care – Medical

(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year)
Harvard Pilgrim Health Care tiers its hospitals based on quality and/or cost:

Tier 1:	$250 per admission
Tier 2:	$500 per admission

Outpatient Surgery

(Maximum four copays per person per calendar year):
$150 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans)*
(Maximum one copay per day): $100 per scan

Emergency Room

$100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

HEALTH NEW ENGLAND HMO

Health New England is an HMO that provides coverage through the plan's network of doctors, hospitals, and other providers. Members must select a Primary Care Provider (PCP) to manage their care; referrals to network specialists are not required. Members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see how your provider is rated.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency care.

Calendar Year Deductible
$250 per individual up to a maximum of $750 per family.
See page 10 for details.

In-Network Out-of-Pocket Maximum
$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

Health New England is available in the following Massachusetts counties:

Berkshire, Franklin, Hampden, Hampshire

Health New England is available only in certain parts of the following Massachusetts county; contact the plan to find out if you live in the service area:

Worcester

Health New England is available only in certain parts of the following state; contact the plan to find out if you live in the service area:

Connecticut

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

YOUR RESPONSIBILITY
Do your doctors and hospitals participate in Health New England? Contact the plan.

Great Value Quality Coverage — Limited ★★★ Network Plan

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Health New England
1.800.842.4464 | www.hne.com/gic

Copays Effective July 1, 2014

Primary Care Provider Office Visit
$20 per visit

Preventive Services
Most covered at 100% – no copay

Specialist Office Visit
Health New England tiers the following specialists based on quality and/or cost efficiency: Cardiologists, Endocrinologists, Gastroenterologists, General Surgeons, Obstetricians/ Gynecologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, and Rheumatologists.

★★★	Tier 1 (excellent):	$25 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care
$20 per visit

Inpatient Hospital Care – Medical
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year):
$250 per admission

Outpatient Surgery
(Maximum four copays per person per calendar year):
$110 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans)*
(Maximum one copay per day):
$100 per scan

Emergency Room
$100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

NHP CARE *(Neighborhood Health Plan)* HMO

NHP Care, administered by Neighborhood Health Plan, is an HMO that provides coverage through the plan's network of doctors, hospitals, and other providers. Members must select a Primary Care Provider (PCP) to manage their care and obtain referrals to specialists. Members pay lower office visit copays when they see Tier 1 and Tier 2 specialists. Contact the plan to see how your provider is rated.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency care.

Calendar Year Deductible

$250 per individual up to a maximum of $750 per family.
See page 10 for details.

In-Network Out-of-Pocket Maximum

$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

NHP Care is available in the following Massachusetts counties:

Barnstable, Bristol, Dukes, Essex, Hampden, Middlesex, Nantucket, Norfolk, Plymouth, Suffolk, Worcester

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

YOUR RESPONSIBILITY
Do your doctors and hospitals participate in NHP Care?
Contact the plan.

GREAT VALUE QUALITY COVERAGE — Limited ★★★ Network Plan

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

NHP Care
1.866.567.9175 | www.nhp.org/gic

Copays Effective July 1, 2014

Primary Care Provider Office Visit
$20 per visit

Preventive Services
Most covered at 100% – no copay

Specialist Office Visit
Neighborhood Health Plan tiers the following specialists based on quality and/or cost efficiency: Cardiologists, Endocrinologists, Gastroenterologists, Obstetricians/Gynecologists, Otolaryngologists (ENTs), Orthopedists, Pulmonologists, and Rheumatologists.

★★★	Tier 1 (excellent):	$25 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care
$20 per visit

Inpatient Hospital Care – Medical
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year):
$250 per admission

Outpatient Surgery
(Maximum four copays annually per person):
$110 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans)*
(Maximum one copay per day):
$100 per scan

Emergency Room
$100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

TUFTS HEALTH PLAN NAVIGATOR PPO

Tufts Health Plan Navigator is a PPO plan that offers coverage through network doctors, hospitals and other health care providers with a copay. Or, you may seek care from an out-of-network provider for 80% coverage of reasonable and customary charges. The plan encourages members to select a Primary Care Provider (PCP). Members pay lower office visit copays when they see Tier 1 and Tier 2 specialists. Contact the plan to see if your provider is in the network and how he/she is rated.

The plan also tiers hospitals based on quality and/or cost; members pay a lower inpatient hospital copay when they use Tier 1 hospitals. Contact the plan to see which tier your hospital is in.

The mental health benefits of this plan, administered by Beacon Health Strategies, offer you in-network benefits with a copay. Or, you may seek care from out-of-network providers, but at higher out-of-pocket costs.

Calendar Year Deductible
$250 per individual up to a maximum of $750 per family.
See page 10 for details.

In-Network Out-of-Pocket Maximum – *Excludes Prescription Drug Costs*
$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

Tufts Health Plan Navigator is available throughout Massachusetts.

The Plan is also available in the following other state:

Rhode Island

Tufts Health Plan Navigator is available only in certain parts of the following states; contact the plan to see if you live in the service area:

Connecticut, New Hampshire, New York, Vermont

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Medical Benefits: Tufts Health Plan
1.800.870.9488 | www.tuftshealthplan.com/gic

Mental Health, Substance Abuse and EAP Benefits: Beacon Health Strategies
1.855.750.8980 | www.beaconhs.com/gic

In-Network Copays Effective July 1, 2014

Primary Care Provider Office Visit: $20 per visit

Preventive Services: Most covered at 100% – no copay

Specialist Office Visit
Tufts Health Plan tiers the following Massachusetts specialists based on quality and/or cost efficiency: Cardiologists, Dermatologists, Endocrinologists, Gastroenterologists, General Surgeons, Neurologists, Obstetricians/Gynecologists, Ophthalmologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, Rheumatologists, and Urologists.

★★★	Tier 1 (excellent):	$25 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care
(See the GIC's website for a Beacon Health Strategies Tufts Navigator benefit grid or contact Beacon for additional benefit details): $20 per visit
Beacon also offers EAP services.

Inpatient Hospital Care – Medical
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year)
Tufts Health Plan tiers hospitals based on quality and/or cost:
Tier 1: $300 per admission
Tier 2: $700 per admission

Outpatient Surgery *(Maximum four copays per person per calendar year):* $150 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans) (Maximum one copay per day):* $100 per scan

Emergency Room: $100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

TUFTS HEALTH PLAN SPIRIT EPO (HMO-TYPE)

Tufts Health Plan Spirit is an Exclusive Provider Organization (EPO) plan that provides coverage through the plan's network of doctors, hospitals and other providers. The plan encourages members to select a Primary Care Provider (PCP).

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency care.

Members pay lower office visit copays when they see Tier 1 and Tier 2 specialists. Contact the plan to see if your provider is in the network and how he/she is rated. The plan also tiers hospitals based on quality and/or cost; members pay a lower inpatient hospital copay when they use Tier 1 hospitals. Contact the plan to see which tier your hospital is in.

The mental health benefits of this plan are administered by Beacon Health Strategies.

Calendar Year Deductible
$250 per individual up to a maximum of $750 per family.
See page 10 for details.

In-Network Out-of-Pocket Maximum – *Excludes Prescription Drug Costs*
$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

Tufts Health Plan Spirit is available in the following Massachusetts counties:

Barnstable, Bristol, Essex, Franklin, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, Worcester

Tufts Health Plan Spirit is available only in certain parts of the following Massachusetts counties; contact the plan to find out if you live in the service area:

Berkshire, Hampshire

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

YOUR RESPONSIBILITY
Do your doctors and hospitals participate in Tufts Spirit? Contact the plan.

Limited ★★★ Network Plan

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Medical Benefits: Tufts Health Plan
1.800.870.9488 | www.tuftshealthplan.com/gic

Mental Health, Substance Abuse and EAP Benefits: Beacon Health Strategies
1.855.750.8980 | www.beaconhs.com/gic

Copays Effective July 1, 2014

Primary Care Provider Office Visit: $20 per visit

Preventive Services: Most covered at 100% – no copay

Specialist Office Visit
Tufts Health Plan tiers the following Massachusetts specialists based on quality and/or cost efficiency: Cardiologists, Dermatologists, Endocrinologists, Gastroenterologists, General Surgeons, Neurologists, Obstetricians/Gynecologists, Ophthalmologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, Rheumatologists, and Urologists.

★★★	Tier 1 (excellent):	$25 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care
(See the GIC's website for a Beacon Health Strategies Tufts Spirit benefit grid or contact Beacon for additional benefit details):
$20 per visit

Beacon also offers EAP services.

Inpatient Hospital Care – Medical *(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year)*
Tufts Health Plan tiers hospitals based on quality and/or cost:
Tier 1: $300 per admission
Tier 2: $700 per admission

Outpatient Surgery *(Maximum four copays per person per calendar year):* $150 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans) (Maximum one copay per day):* $100 per scan

Emergency Room: $100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

UNICARE STATE INDEMNITY PLAN/BASIC INDEMNITY

The UniCare State Indemnity Plan/Basic offers access to any licensed doctor or hospital throughout the United States and outside of the country. Massachusetts members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see how a physician is rated.

The plan determines allowed amounts for out-of-state providers; you may be responsible for a portion of the total charge. To avoid these additional provider charges, if you use non-Massachusetts doctors or hospitals, contact the plan to find out which doctors and hospitals in your area participate in UniCare's national network of providers.

The mental health benefits of this plan, administered by Beacon Health Strategies, offer you a choice of using network providers and paying a copayment, or seeking care from out-of-network providers at higher out-of-pocket costs.

Prescription drug benefits are administered by CVS Caremark.

Calendar Year Deductible

$250 per individual up to a maximum of $750 per family. *See page 10 for details.*

In-Network Out-of-Pocket Maximum – *Excludes Prescription Drug Costs*

$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

The UniCare State Indemnity Plan/Basic is the only plan offered by the GIC that is available throughout the United States and outside of the country.

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information on benefits and the national network of providers.

Medical Benefits: UniCare
1.800.442.9300 | www.unicarestateplan.com

Mental Health, Substance Abuse and EAP Benefits: Beacon Health Strategies
1.855.750.8980 | www.beaconhs.com/gic

Prescription Drug Benefits: CVS Caremark
1.877.876.7214 | www.caremark.com/gic

Copays with CIC *(Comprehensive)* Effective July 1, 2014

Without CIC, deductibles are higher and coverage is only 80% for some services. Contact the plan for details.

Primary Care Provider Office Visit: $20 per visit

Preventive Services: Most covered at 100% – no copay

Specialist Office Visit
UniCare tiers Massachusetts specialists based on quality and/or cost efficiency:

★★★	Tier 1 (excellent):	$25 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Network Outpatient Mental Health and Substance Abuse Care *(See the GIC's website for a Beacon Health Strategies UniCare Basic benefit grid or contact Beacon for additional benefit details):* $20 per visit
Beacon also offers EAP services.

Inpatient Hospital Care – Medical
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year): $200 per admission

Outpatient Surgery *(Maximum one copay per person per calendar year quarter):* $110 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans) (Maximum one copay per day):* $100 per scan

Emergency Room: $100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

UNICARE STATE INDEMNITY PLAN/ COMMUNITY CHOICE PPO-TYPE

The UniCare State Indemnity Plan/Community Choice is a PPO-type plan with a hospital network based at community and some tertiary hospitals. Or, you may seek care from an out-of-network hospital for 80% coverage of the allowed amount for inpatient care and outpatient surgery, after you pay a copay. **Contact the plan to see if your hospital is in the network.**

The plan offers access to all Massachusetts physicians and members are encouraged to select a Primary Care Provider (PCP). Members pay lower office visit copays when they see Tier 1 and Tier 2 specialists. Contact the plan to see how a physician is rated.

The mental health benefits of this plan, administered by Beacon Health Strategies, offer you a choice of using network providers and paying a copayment, or seeking care from out-of-network providers at higher out-of-pocket costs.

Prescription drug benefits are administered by CVS Caremark.

Calendar Year Deductible

$250 per individual up to a maximum of $750 per family. *See page 10 for details.*

In-Network Out-of-Pocket Maximum – *Excludes Prescription Drug Costs*

$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

The UniCare State Indemnity Plan/Community Choice is available in the following Massachusetts counties:

Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

YOUR RESPONSIBILITY
Are your hospitals in the UniCare Community Choice network? Contact the plan.

GREAT VALUE QUALITY COVERAGE Limited ★★★ Network Plan

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Medical Benefits: UniCare
1.800.442.9300 | www.unicarestateplan.com

Mental Health, Substance Abuse and EAP Benefits: Beacon Health Strategies
1.855.750.8980 | www.beaconhs.com/gic

Prescription Drug Benefits: CVS Caremark
1.877.876.7214 | www.caremark.com/gic

In-Network Copays Effective July 1, 2014

Primary Care Provider Office Visit: $20 per visit

Preventive Services: Most covered at 100% – no copay

Specialist Office Visit
UniCare tiers Massachusetts specialists based on quality and/or cost efficiency:

★★★	Tier 1 (excellent):	$25 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care
(See the GIC's website for a Beacon Health Strategies UniCare Community Choice benefit grid or contact Beacon for additional benefit details): $20 per visit

Beacon also offers EAP services.

Inpatient Hospital Care – Medical
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year): $250 per admission

Outpatient Surgery *(Maximum one copay per person per calendar year quarter):* $110 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans) (Maximum one copay per day):* $100 per scan

Emergency Room: $100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

UNICARE STATE INDEMNITY PLAN/PLUS PPO-TYPE

The UniCare State Indemnity Plan/PLUS is a PPO-type plan that provides access to all Massachusetts physicians and hospitals and out-of-state UniCare providers at 100% coverage, after a copayment. Out-of-state non-UniCare providers have 80% coverage of allowed charges. Members are encouraged to select a Primary Care Provider (PCP) to manage their care. Members will also pay a lower copay if they see a Centered Care PCP. Contact the plan to find out if your PCP is a Centered Care provider.

Members pay lower office visit copays when they see Tier 1 and Tier 2 specialists. Contact the plan to see how a physician is rated. The plan also tiers hospitals based on quality and/or cost; members pay a lower inpatient hospital and outpatient surgery copay when they use Tier 1 or Tier 2 hospitals. Contact the plan to see which tier your hospital is in.

The mental health benefits of this plan, administered by Beacon Health Strategies, offer you a choice of using network providers and paying a copayment, or seeking care from out-of-network providers at higher out-of-pocket costs. Prescription drug benefits are administered by CVS Caremark.

Calendar Year Deductible

$250 per individual up to a maximum of $750 per family. *See page 10 for details.*

In-Network Out-of-Pocket Maximum – *Excludes Prescription Drug Costs*

$5,000 per individual; $10,000 per family

Who is Eligible?

Employees, Retirees, Survivors, and their eligible dependents without Medicare are eligible.

Where You Live Determines Which Plan You May Enroll In

The UniCare State Indemnity Plan/PLUS is available throughout Massachusetts.

The plan is also available in the following other states:

Maine, New Hampshire, Rhode Island

The UniCare State Indemnity Plan/PLUS is available only in certain parts of the following state; contact the plan to find out if you live in the service area:

Connecticut

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Medical Benefits: UniCare
1.800.442.9300 | www.unicarestateplan.com

Mental Health, Substance Abuse and EAP Benefits: Beacon Health Strategies
1.855.750.8980 | www.beaconhs.com/gic

Prescription Drug Benefits: CVS Caremark
1.877.876.7214 | www.caremark.com/gic

In-Network Copays Effective July 1, 2014

Primary Care Provider Office Visit
$15 per visit for Centered Care PCPs
$20 per visit for other PCPs

Preventive Services: Most covered at 100% – no copay

Specialist Office Visit: *UniCare tiers Massachusetts specialists based on quality and/or cost efficiency:*

★★★	Tier 1 (excellent):	$25 per visit
★★	Tier 2 (good):	$35 per visit
★	Tier 3 (standard):	$45 per visit

Retail Clinic: $20 per visit

Outpatient Mental Health and Substance Abuse Care
(See the GIC's website for a Beacon Health Strategies UniCare PLUS benefit grid or contact Beacon for additional benefit details):
$20 per visit
Beacon also offers EAP services.

Inpatient Hospital Care – Medical
UniCare tiers hospitals based on quality and/or cost
(Maximum one copay per person per calendar year quarter; waived if readmitted within 30 days in the same calendar year):

Tier 1:	$250 per admission
Tier 2:	$500 per admission
Tier 3:	$750 per admission

Outpatient Surgery: *UniCare's outpatient surgery copay is based on the hospital's tier, with Tier 1 and Tier 2 hospitals having the same outpatient surgery copay (Maximum one copay per person per calendar year quarter).*
Tier 1 and Tier 2: $110 per occurrence
Tier 3: $250 per occurrence

High-Tech Imaging *(e.g., MRI, PET and CT scans)*
(Maximum one copay per day): $100 per scan

Emergency Room: $100 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

YOUR RESPONSIBILITY
Do your doctors and hospitals participate in Fallon Senior Plan? Contact the plan.

FALLON SENIOR PLAN HMO

Fallon Senior Plan is a Medicare Advantage HMO plan that provides coverage through the plan's network of doctors, hospitals, and other providers. Members must select a Primary Care Physician (PCP) to manage their care and obtain referrals to specialists.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency care.

Fallon Senior Plan is a Medicare plan under contract with the federal government that includes Medicare Part D prescription drug benefits. Contact the plan for details. ***This Medicare plan's benefits and rates are subject to federal approval and may change January 1, 2015.***

Who is Eligible?

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B are eligible.

Where You Live Determines Which Plan You May Enroll In

Fallon Senior Plan is available in the following Massachusetts counties:

Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester

Fallon Senior Plan is available only in certain parts of the following Massachusetts county; contact the plan to find out if you live in the service area:

Franklin

Fallon Senior Plan is only available in certain parts of the following states; contact the plan to find out if you live in the service area:

Connecticut, New Hampshire, Rhode Island

Monthly Rates Effective January 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Fallon Senior Plan
1.866.344.4442
www.fchp.org/gic

You may change plans *ONLY* during the GIC's Spring Annual Enrollment period, even though the plan's providers may change on a calendar year basis.

Copays Effective January 1, 2014

Physician Office Visit
$10 per visit

Preventive Services
Covered at 100% – no copay

Outpatient Mental Health and Substance Abuse Care
$10 per visit

Inpatient Hospital Care
Covered at 100% – no copay

Inpatient and Outpatient Surgery
Covered at 100% – no copay

Emergency Room
$50 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	*Mail Order up to 90-day supply:*
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

HARVARD PILGRIM MEDICARE ENHANCE INDEMNITY

Harvard Pilgrim Medicare Enhance is a supplemental Medicare plan, offering coverage for services provided by any licensed doctor or hospital throughout the United States that accepts Medicare payment.

Who is Eligible?

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B are eligible.

Where You Live Determines Which Plan You May Enroll In

The Harvard Pilgrim Medicare Enhance Plan is available throughout the United States.

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information.

Harvard Pilgrim Medicare Enhance
1.800.542.1499
www.harvardpilgrim.org/gic

Copays Effective July 1, 2014

Physician Office Visit
$10 per visit

Preventive Services
Covered at 100% – no copay

Retail Clinic
$10 per visit

Outpatient Mental Health and Substance Abuse Care
$10 per visit

Inpatient Hospital Care
Covered at 100% – no copay

Inpatient and Outpatient Surgery
Covered at 100% – no copay

Emergency Room
$50 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

YOUR RESPONSIBILITY
Do your doctors and hospitals participate in Health New England MedPlus? Contact the plan.

HEALTH NEW ENGLAND MEDPLUS HMO

Health New England MedPlus is a Medicare HMO plan that provides coverage through the plan's network of doctors, hospitals, and other providers. Members must select a Primary Care Physician (PCP) to manage their care; referrals to network specialists are not required.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency and urgent care.

Who is Eligible?

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B are eligible.

Where You Live Determines Which Plan You May Enroll In

Health New England MedPlus is available in the following Massachusetts counties:

Berkshire, Franklin, Hampden, Hampshire

Health New England MedPlus is available only in certain parts of the following Massachusetts county; contact the plan to find out if you live in the service area:

Worcester

Health New England MedPlus is available only in certain parts of the following state; contact the plan to find out if you live in the service area:

Connecticut

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Health New England MedPlus
1.800.842.4464
www.hne.com/gic

Copays Effective July 1, 2014

Physician Office Visit
$10 per visit

Preventive Services
Covered at 100% – no copay

Retail Clinic
$10 per visit

Outpatient Mental Health and Substance Abuse Care
$10 per visit

Inpatient Hospital Care
Covered at 100% – no copay

Inpatient and Outpatient Surgery
Covered at 100% – no copay

Emergency Room
$50 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	*Mail Order up to 90-day supply:*
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

YOUR RESPONSIBILITY
Do your doctors and hospitals participate in Tufts Medicare Complement? Contact the plan.

TUFTS HEALTH PLAN MEDICARE COMPLEMENT HMO

Tufts Health Plan Medicare Complement is a supplemental Medicare HMO plan that provides coverage through the plan's network of doctors, hospitals, and other providers. Members must select a Primary Care Physician (PCP) to manage their care and obtain referrals to specialists.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency and urgent care.

Who is Eligible?

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B are eligible.

Where You Live Determines Which Plan You May Enroll In

Tufts Health Plan Medicare Complement is available throughout Massachusetts.

The plan is also available in the following other state:

Rhode Island

Tufts Health Plan Medicare Complement is available only in certain parts of the following states; contact the plan to find out if you live in the service area:

Connecticut, New Hampshire, New York, Vermont

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Tufts Health Plan Medicare Complement
1.888.333.0880
www.tuftshealthplan.com/gic

Copays Effective July 1, 2014

Physician Office Visit
$10 per visit

Preventive Services
Covered at 100% – no copay

Retail Clinic
$10 per visit

Outpatient Mental Health and Substance Abuse Care
$10 per visit

Inpatient Hospital Care
Covered at 100% – no copay

Inpatient and Outpatient Surgery
Covered at 100% – no copay

Emergency Room
$50 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

YOUR RESPONSIBILITY
Do your doctors and hospitals participate in Tufts Medicare Preferred? Contact the plan.

TUFTS HEALTH PLAN MEDICARE PREFERRED HMO

Tufts Health Plan Medicare Preferred HMO is a Medicare Advantage plan that provides coverage through the plan's network of doctors, hospitals, and other providers. Members must select a Primary Care Physician (PCP) to manage their care and obtain referrals to specialists.

Contact the plan to see if your doctors and hospitals are in the network. There are no out-of-network benefits, with the exception of emergency care.

Tufts Health Plan Medicare Preferred HMO is a Medicare Advantage plan under contract with the federal government that includes Medicare Part D prescription drug benefits. Contact the plan for details. ***This Medicare plan's benefits and rates are subject to federal approval and may change January 1, 2015.***

Who is Eligible?

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B are eligible.

Where You Live Determines Which Plan You May Enroll In

Tufts Health Plan Medicare Preferred is available in the following Massachusetts counties:

Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester

Monthly Rates Effective January 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional information on participating providers and benefits.

Tufts Health Plan Medicare Preferred
1.888.333.0880
www.tuftshealthplan.com/gic

You may change plans *ONLY* during the GIC's Spring Annual Enrollment period, even though the plan's providers may change on a calendar year basis.

Copays Effective January 1, 2014

Physician Office Visit
$10 per visit

Preventive Services
Covered at 100% – no copay

Outpatient Mental Health and Substance Abuse Care
$10 per visit

Inpatient Hospital Care
Covered at 100% – no copay

Inpatient and Outpatient Surgery
Covered at 100% – no copay

Emergency Room
$50 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	*Mail Order up to 90-day supply:*
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

UNICARE STATE INDEMNITY PLAN/MEDICARE EXTENSION (OME) INDEMNITY

The UniCare State Indemnity Plan/Medicare Extension (OME) is a supplemental Medicare plan offering access to any licensed doctor or hospital throughout the United States and outside of the country. The mental health benefits of this plan, administered by Beacon Health Strategies, offer you in-network benefits with a copay. Or, you may seek care out-of-network, but at higher out-of-pocket costs. Prescription drug benefits are administered by CVS Caremark.

Who is Eligible?

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B are eligible.

Where You Live Determines Which Plan You May Enroll In

The UniCare State Indemnity Plan/Medicare Extension (OME) is available throughout the United States and outside of the country.

Monthly Rates Effective July 1, 2014

Municipal enrollees will receive a separate rate chart.

Plan Contact Information

Contact the plan for additional benefit information.

Medical Benefits: UniCare
1.800.442.9300 | www.unicarestateplan.com

Mental Health, Substance Abuse and EAP Benefits: Beacon Health Strategies
1.855.750.8980 | www.beaconhs.com/gic

Prescription Drug Benefits: CVS Caremark
1.877.876.7214 | www.caremark.com/gic

Copays with CIC *(Comprehensive)* Effective July 1, 2014

Without CIC, deductibles are higher and coverage is only 80% for some services. Contact the plan for details.

Calendar Year Deductible
$35 per person

Physician Office Visit
None

Preventive Services
Covered at 100% – no copay

Retail Clinic
None

Network Outpatient Mental Health and Substance Abuse Care *(See the GIC's website for a Beacon Health Strategies UniCare OME benefit grid or contact Beacon for additional benefit details)*
First four visits $0; visits 5 and over: $10 per visit
Beacon also offers EAP services.

Inpatient Hospital Care *(Maximum one copay per person per calendar year quarter):*
$50 per admission

Inpatient and Outpatient Surgery: Covered at 100% – no copay – in Massachusetts and for out-of-state providers who accept Medicare; call the plan for details if using out-of-state providers who do not accept Medicare

Emergency Room
$25 per visit (waived if admitted)

Prescription Drug

Retail up to 30-day supply:	***Mail Order up to 90-day supply:***
Tier 1: $10	Tier 1: $20
Tier 2: $25	Tier 2: $50
Tier 3: $50	Tier 3: $110

GIC Retiree Dental Plan

Metropolitan Life Insurance Company (MetLife) is the provider of the GIC Retiree Dental Plan. The plan offers a fixed reimbursement of up to $1,250 per member per year for dental services:

- Dental examinations
- Dental cleanings
- Fillings
- Crowns
- Dentures
- Dental implants

As a member of this plan, you may go to the dentist of your choice. However, you will save money by visiting one of the over 226,000 nationwide network of participating dentists. When you visit a MetLife provider, your out-of-pocket expenses will be lower as you usually pay the lower negotiated fee, even after you have exceeded your annual maximum.

This is an entirely voluntary plan (retiree-pay-all) that provides GIC members with coverage at discounted group insurance rates through convenient pension deductions.

ELIGIBILITY

Retirees and survivors from the following municipalities that have elected to offer the plan are eligible:

- City of Melrose
- City of Peabody
- City of Pittsfield
- Town of Bedford
- Town of Brookline
- Town of Holbrook
- Town of Holden
- Town of Hopedale
- Town of Millis
- Town of North Andover
- Town of Randolph
- Athol Roylston School District
- Northeast Metropolitan Regional Vocational School District

If your municipality is not listed, you are not eligible for GIC Retiree Dental benefits. Contact your municipal benefits office for additional information.

Enrollment

Eligible retirees and survivors may join during annual enrollment, when COBRA dental coverage ends, when they become a survivor of a GIC member, or at retirement.

However, if you drop coverage in the future, you can never re-enroll in the plan.

GIC RETIREE DENTAL PLAN

Includes 0.40% Administrative Fee

MONTHLY GIC Plan Rates Effective July 1, 2014

$1,250 Maximum Annual Benefit per Member

COVERAGE TYPE	RETIREE PAYS MONTHLY
SINGLE	$28.34
FAMILY	$68.27

Retiree Dental Questions?
Contact MetLife: 1.866.292.9990
www.metlife.com/gic

Attend a Health Fair

Municipal members who are enrolling in GIC benefits for the first time, thinking about changing health plans, or have other health plan questions can attend one of the GIC's health fairs to:

- Speak with health and other benefit plan representatives;
- Pick up detailed materials and provider directories;
- Ask GIC staff about your benefit options;
- Enroll in a health plan – remember to bring Required Documents with you *(for the list, see the Municipal Forms section of our website)*; and
- Take advantage of complimentary health screenings.

See page 35 for the schedule.

Inscripción Anual

La inscripción anual tendrá lugar a partir del 9 de abril hasta el 7 de mayo del 2014. Durante dicho período, usted como (empleado o jubilado del estado) tendrá la oportunidad de inscribirse o cambiar su seguro de salud. Si desea mantener los beneficios del seguro de salud que actualmente tiene no hace falta que haga nada. Su cobertura continúa en forma automática.

Usted deberá permanecer en el plan de salud que seleccionó hasta el próximo período de inscripción anual aunque su médico o hospital se salgan del plan, a menos que usted se mude fuera del área de servicio o es elegible para Medicare.

Los cambios de cobertura entrarán en vigencia el 1 de julio del 2014. Para obtener más información, sírvase llamar a Group Insurance Commission (Comisión de Seguros de Grupo) al 617.727.2310, extensión 1. Hay empleados que hablan español que le ayudarán.

年度登記

年度投保從 2014 年 4 月 9 日開始，到 5 月 7 日結束。在這段期間，您 (因為您是這個州的員工或退休員工) 有機會可以投保或變更您的健康保險。如果您希望維持您目前的健康保險福利，則什麼都不必做。您的承保會自動持續。

即使您的醫師或醫院退出本計畫，您仍須維持您目前選擇的健保計畫，直到下一次開放投保期間才可以變更，除非是您搬離服務區域或是您符合 Medicare 的資格。

任何承保變更都會在 2014 年 7 月1 日生效。欲查詢詳情，請致電 Group Insurance Commission，電話 617.727.2310，分機 1。

我們有講中文的員工可以幫助您。

Our Website Provides Additional Helpful Information

www.mass.gov/gic

See our website for:

- *Benefit Decision Guide* content in HTML and XML-accessible formats;
- Information about and links to all GIC plans – conveniently search for participating health plan doctors and hospitals online;
- The latest annual enrollment news;
- Forms to expedite your annual enrollment decisions;
- Answers to frequently asked questions including what to do when you turn age 65;
- GIC publications – including the *Benefits At-a-Glance* brochures and *For Your Benefit* newsletters;
- Summary of Benefits and Coverage for all GIC employee/Non-Medicare health plans;
- Benefits At-A-Glance charts for mental health and substance abuse benefits for all UniCare State Indemnity plans and Tufts Health Plan Navigator and Spirit members; and
- Health articles and links to help you take charge of your health.

Ghi danh hàng năm

Thời gian ghi danh hàng năm bắt đầu vào ngày 9 tháng 4 và chấm dứt vào ngày 7 tháng 5, năm 2014. Trong khoảng thời gian này, quý vị (với tư cách là nhân viên hoặc nhân viên hưu trí của tiểu bang) có cơ hội để ghi danh hoặc đổi chương trình bảo hiểm sức khỏe. Nếu muốn giữ chương trình bảo hiểm sức khỏe hiện tại của mình, quý vị không cần phải làm gì cả. Bảo hiểm của quý vị sẽ được tự động tiếp tục.

Quý vị phải giữ chương trình bảo hiểm sức khỏe hiện tại mà quý vị chọn cho đến thời gian ghi danh hàng năm kế tiếp, ngay cả khi bác sĩ hoặc bệnh viện của quý vị không còn tham gia trong chương trình, trừ khi quý vị di chuyển ra khỏi khu vực phục vụ của chương trình hoặc khi quý vị hội đủ điều kiện được hưởng chương trình Medicare.

Những thay đổi của quý vị sẽ có hiệu lực vào ngày 1 tháng 7, năm 2014. Để biết thêm thông tin chi tiết, xin quý vị gọi cho Group Insurance Commission tại số 617.727.2310, số nội bộ 1.

Có nhân viên nói tiếng Việt giúp đỡ quý vị.

APRIL 2014

11 **FRIDAY** 11:00-2:00
Berkshire Community College
Paterson Field House
1350 West Street
PITTSFIELD

12 **SATURDAY** 10:00-2:00
Mass Maritime Academy
Gymnasium
101 Academy Drive
BUZZARDS BAY

15 **TUESDAY** 11:00-3:00
State Transportation Building
10 Park Plaza, 2nd Floor
Conference Rooms 1, 2 and 3
BOSTON

16 **WEDNESDAY** 11:00-4:00
Middleborough Town Hall
Grand Ballroom, 2nd Floor
10 Nickerson Avenue
MIDDLEBOROUGH

17 **THURSDAY** 10:00-3:00
Quinsigamond Community College
Harrington Learning Center, Rooms 109 AB
670 West Boylston Street
WORCESTER

19 **SATURDAY** 11:00-2:00
Northern Essex Community College
The Technology Center, Rooms 103 A & B
100 Elliott Street
HAVERHILL

23 **WEDNESDAY** 10:00-3:00
McCormack State Office Building
One Ashburton Place, 21st Floor
BOSTON

24 **THURSDAY** 11:00-3:00
Wrentham Developmental Center
Graves Auditorium
Littlefield Street
WRENTHAM

25 **FRIDAY** 11:00-4:00
Framingham Town Hall
Nevins Hall, 1st Floor
150 Concord Street
FRAMINGHAM

28 **MONDAY** 11:00-4:00
East Bridgewater Junior/Senior High School
Gymnasium
143 Plymouth Street
EAST BRIDGEWATER

MAY 2014

1 **THURSDAY** 11:00-3:00
U-Mass Amherst
Student Union Ballroom
AMHERST

2 **FRIDAY** 10:00-2:00
Hampden County Sheriff's Department
Hampden County Correctional Center
627 Randall Road
LUDLOW

Commonwealth of Massachusetts
Group Insurance Commission

FOR MORE INFORMATION, CONTACT THE PLANS

For more information about specific plan benefits, call a plan representative. Be sure to indicate you are a GIC insured.

HEALTH INSURANCE		
Fallon Health Direct Care Select Care Senior Plan	1.866.344.4442	www.fchp.org/gic
Harvard Pilgrim Health Care Independence Plan Primary Choice Plan Medicare Enhance	1.800.542.1499	www.harvardpilgrim.org/gic
Health New England HMO MedPlus	1.800.842.4464	www.hne.com/gic
Neighborhood Health Plan NHP Care	1.866.567.9175	www.nhp.org/gic
Tufts Health Plan Navigator Spirit • Mental Health/Substance Abuse and EAP *(Beacon Health Strategies)* Medicare Complement Medicare Preferred	1.800.870.9488 1.855.750.8980 1.888.333.0880	www.tuftshealthplan.com/gic www.beaconhs.com/gic www.tuftshealthplan.com/gic
UniCare State Indemnity Plan/ Basic Community Choice Medicare Extension (OME) PLUS *For all UniCare Plans* • Prescription Drugs *(CVS Caremark)* • Mental Health/Substance Abuse and EAP *(Beacon Health Strategies)*	1.800.442.9300 1.877.876.7214 1.855.750.8980	www.unicarestateplan.com www.caremark.com/gic www.beaconhs.com/gic
OTHER BENEFITS		
GIC Retiree Dental Plan *(MetLife)*	1.866.292.9990	www.metlife.com/gic
ADDITIONAL RESOURCES		
Employee Assistance Program for Managers and Supervisors *(Beacon Health Strategies)*	1.855.750.8980	www.beaconhs.com/gic
Internal Revenue Service (IRS)	1.800.829.1040	www.irs.gov
Massachusetts Teachers' Retirement System	1.617.679.6877 (Eastern MA) 1.413.784.1711 (Western MA)	www.mass.gov/mtrs
Medicare	1.800.633.4227	www.medicare.gov
Social Security Administration	1.800.772.1213	www.ssa.gov

OTHER QUESTIONS?

Call the GIC: 1.617.727.2310, ext. 1, TDD/TTY: 1.617.227.8583 • www.mass.gov/gic

Centered Care – a GIC program that seeks to improve health care coordination and quality while reducing costs. Primary Care Providers play a critical role in helping their patients get the right care at the right place with the right provider. The central idea is to coordinate health care services around the needs of you, the patient. Because health care is so expensive, Centered Care also seeks to engage providers and health plans on managing these dollars more efficiently.

CIC (Catastrophic Illness Coverage) – an optional part of the UniCare State Indemnity Plan/Basic and Medicare Extension (OME) plans. CIC increases the benefits for most covered services to 100%, subject to deductibles and copayments. Enrollees ***without*** CIC receive only 80% coverage for some services and pay higher deductibles. Over 99% of current Indemnity Plan Basic and Medicare Extension Plan members select CIC.

COBRA (Consolidated Omnibus Budget Reconciliation Act) – a federal law that allows enrollees to continue their health coverage for a limited period of time after their group coverage ends as the result of certain employment or life event changes.

CPI (Clinical Performance Improvement) **Initiative** – a GIC program that seeks to improve health care quality while containing costs for the Commonwealth and our members. Claims data from all six GIC health carriers are aggregated to identify differences in physician quality and cost efficiency, and this information is given back to the plans to tier specialists. Members who choose to see high-performing doctors pay lower copays.

Deductible – a set dollar amount which must be satisfied within a calendar year before the health plan begins making payments on claims.

Deferred Retirement – allows you to continue your group health insurance after you leave municipality service with vested pension rights until you begin to collect a pension. Until you receive a retirement allowance, you will be responsible for the entire health insurance premium costs, for which you are billed directly. If you withdraw your pension money, you are not eligible for GIC coverage.

EAP (Enrollee Assistance Program) – mental health services that include help for depression, marital issues, family problems, alcohol and drug abuse, and grief. Also includes referral services for legal, financial, family mediation, and elder care assistance.

EPO (Exclusive Provider Organization) – a health plan that provides coverage for treatment by a network of doctors, hospitals and other health care providers within a certain geographic area. EPOs do not offer out-of-network benefits, with the exception of emergency care. An EPO encourages the selection of a Primary Care Provider (PCP).

GIC (Group Insurance Commission) – a quasi-independent state agency governed by a 17-member commission appointed by the Governor. The mission of the GIC is to provide high-value health insurance and certain other benefits to state, particular authority, and participating municipality employees, retirees, and their survivors and dependents.

HMO (Health Maintenance Organization) – a health plan that provides coverage for treatment by a network of doctors, hospitals and other health care providers within a certain geographic area. HMOs do not offer out-of-network benefits, with the exception of emergency care. An HMO requires the selection of a Primary Care Provider (PCP).

Networks – groups of doctors, hospitals and other health care providers that contract with a benefit plan. If you are in a plan that offers both network and non-network coverage, you will receive the maximum level of benefits when you are treated by network providers.

PCP (Primary Care Provider) – physicians with specialties in internal medicine, family practice, and pediatrics as well as nurse practitioners and physician assistants who coordinate their patients' health care.

PPO (Preferred Provider Organization) – a health insurance plan that offers coverage by network doctors, hospitals, and other health care providers, but also provides a lower level of benefits for treatment by out-of-network providers. A PPO plan encourages the selection of a Primary Care Provider (PCP).

Preventive Services – generally, health care services, such as routine physicals, that do not treat an illness, injury or a condition.

RMT (GIC Retired Municipal Teacher) – a retired teacher from a city, town or school district who is receiving a pension from the Teacher's Retirement Board and whose municipality has elected to participate in the GIC RMT program. Retired teachers who transfer to municipal coverage as part of the municipality joining the GIC for health-only benefits are no longer GIC RMTs.

39-Week Layoff Coverage – allows laid-off insureds to continue their group health insurance for up to 39 weeks (about 9 months) by paying the full cost of the premium.

Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747
Boston, MA 02114

COMMONWEALTH OF MASSACHUSETTS

Deval L. Patrick, *Governor*

Group Insurance Commission
Dolores L. Mitchell, *Executive Director*
19 Staniford Street, 4th Floor
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Telephone: 617.727.2310

TDD/TTY: 617.227.8583

MAILING ADDRESS

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