

See inside
for benefit
changes.



Commonwealth of Massachusetts
Group Insurance Commission

Your
Benefits
Connection

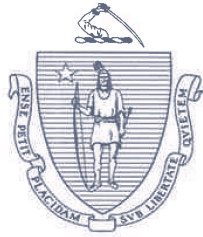
GLC Benefit Decision Guide

FOR COMMONWEALTH
OF MASSACHUSETTS
EMPLOYEES

Benefits and Rates Effective July 1, 2017
Weigh Your Options

ANNUAL ENROLLMENT
APRIL 5 - MAY 3, 2017

2017-2018



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Spring 2017

Dear Colleagues:

The Group Insurance Commission (GIC) is committed to providing quality and affordable benefit plans to Massachusetts state and municipal employees, despite the overall growth of health care costs. I encourage you to be an active consumer and take the time to read this **2017-2018 Benefit Decision Guide** to research available GIC plans.

The GIC is moving forward with a balanced approach to control costs so that state and municipal employees and retirees can continue to have access to comprehensive benefits. Be sure to read this pamphlet to understand how benefits will be changing and the many options available to you.

The health plan in which you are currently enrolled may be changing from last year. Therefore, it is particularly important for you to review your options to ensure you are enrolled in a plan that is best for you and your health care needs. Take advantage of GIC resources for selecting your health plan, including the GIC's website (mass.gov/gic), your GIC Coordinator, the annual enrollment video (mass.gov/gic/aevideo), the health plan websites and call centers, and health fairs across the state.

Thank you for your service and for helping us to move forward with sustainable benefit programs.

Sincerely,

A handwritten signature in dark ink that reads "Charles Baker".

Charles D. Baker
Governor

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.



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Watch the Annual Enrollment video to find out the steps you should take during Annual Enrollment and how to lower your out-of-pocket costs: mass.gov/gic/aevideo.

IMPORTANT REMINDERS:

- This *Benefit Decision Guide* contains important benefit and rate changes effective July 1, 2017. Review pages 5-7, and 13 for details.
- Read *Gather, Investigate, Choose* on page 3 to find out what steps to take during Annual Enrollment.
- Read the *Consider Enrolling in a Less Expensive Plan* section on page 2 to find out more about limited and broad network plan options and your responsibility before enrolling in a plan.
- If you want to **keep your current 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 status change, such as moving out of the plan's service area or retiring and becoming Medicare eligible (in which case, you **must** enroll in a Medicare plan).

- Completed annual enrollment forms are due to the GIC Coordinator in your benefits office and Buy-Out forms to the GIC **no later than Wednesday, May 3, 2017**. Forms and applications are available on the GIC's website (mass.gov/gic/forms). Changes go into effect July 1, 2017.

Consider Enrolling in a Less Expensive Plan



TAKE ACTION DURING ANNUAL ENROLLMENT!

Gather – a list of doctors, hospitals and medications

Investigate – your options by reading this *Benefit Decision Guide* and contacting the health plans you're considering

Choose – a plan no later than May 3

Limited Network Plans Offer an Affordable Option

Limited network plans help address differences in provider costs. You will enjoy **the same benefits** as the 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 contribution; and
- Whether you have individual or family coverage.

For example, if you pay 25% of the premium and have individual coverage, by enrolling in the same health plan's limited network option instead of a wide network option, you **will save, on average, \$45.72 per month and \$548.67 per year.**

See page 13 to determine what the savings would be for the plans you are considering.



Limited Network Plan

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

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

For participating physician and other provider details, contact the individual plans by phone or visit their website (see page 31).

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 29 area hospitals and another six "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 56 hospitals. The plan is available throughout Massachusetts, except for Cape Cod, Martha's Vineyard, and Nantucket.

Health New England – a western and central Massachusetts-based HMO that includes 20 Massachusetts hospitals.

Tufts Health Plan Spirit – an EPO (HMO-type) plan with a network of 54 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 58 hospitals. All Massachusetts physicians participate. The plan is available throughout Massachusetts, except for Martha's Vineyard and Nantucket.

Other Health Plan Options

If you don't want a limited network plan, take a look at NHP Prime and UniCare State Indemnity Plan/PLUS. Information on these plans is on pages 17 and 18-19.

Your Responsibility Before You Enroll in a Health Plan

Once you choose a plan, you cannot change health plans during the year, unless you move out of the plan's service area. 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.

» **G**ather

Gather a list of your doctors, hospitals and medications that you take frequently. Be sure to include this same information for every family member you cover.

» **I**nvestigate

Investigate your options by reading this *Benefit Decision Guide* and contacting the health plans:


- Are your doctors and hospitals in the network?
- What are the copay tiers of your providers? This determines your copay costs.
- Are other services you might need covered?
- Are your prescription drugs included on the plan's formulary, and if so, what copay tier are they in?
- Weigh total expected copay costs and premiums for each plan before you decide to remain in the same health plan or change to another option.


» **C**hoose

Choose your health plan no later than **Wednesday, May 3**. See page 1 for form procedures.

Don't forget other benefit options, including pre-tax **Flexible Spending Accounts, Long Term Disability, Optional Life Insurance, Buy-Out and Dental/Vision** (see pages 21-27 for eligibility and other details). See important reminders on page 1.



 Find out how to “GIC” by watching the Annual Enrollment video
mass.gov/gic/aevideo

 Do your homework during Annual Enrollment—even if you think you want to stay in the same plan

Keep in Mind

- Physician and hospital copay tiers can change each July 1. During Annual Enrollment, check to see if your doctor's or hospital's tier has changed.
- When checking provider coverage and tiers, be sure to specify the health plan's full name, such as “Tufts Health Plan *Spirit*” or “Tufts Health Plan *Navigator*,” not just “Tufts Health Plan.” The health plan is the best source of this information (see page 31).
- 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. Your health plan will help you find another provider.

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 want to keep your current 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.

See your GIC Coordinator or the GIC's website for coverage effective date details.

You may enroll in one of these health plans...

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

You may enroll in...

- Basic Life Insurance
- Optional Life Insurance
- Long Term Disability (LTD)
- GIC Dental/Vision Plan for managers*
- Flexible Spending Account (FSA) benefits
- Pre-tax or post-tax Basic Life and Health Insurance premium deductions

By submitting within 10 days of employment...

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

NOTE: Active state employees who have a qualifying status change during the year may enroll in GIC health coverage within 60 days of the qualifying event. *See page 9 for additional information.*

✓ **Indicates this is a GIC Limited Network Plan.**



Once you choose a health plan, you cannot change plans until the next annual enrollment.

This is true even if your doctor or hospital leaves the plan, unless you have a qualifying status change, such as moving out of the plan's service area or retiring and becoming eligible for Medicare (in which case, you must switch to a Medicare plan). *See page 9 for more information.*

CURRENT EMPLOYEES

During Annual Enrollment April 5-May 3, 2017 for changes effective July 1, 2017

You may enroll in or change your selection of...

One of these health plans:

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

GIC Dental/Vision Plan for Managers*

You may enroll in...

- Basic Life Insurance
- Flexible Spending Account (FSA) benefits

You may apply for*...

- Long Term Disability (during annual enrollment or anytime during the year)
- Optional Life Insurance (during annual enrollment or anytime during the year)
- Health Insurance Buy-Out
- Opt in or out of pre-tax Basic Life and Health Insurance premium deductions

By submitting by May 3...

Completed GIC enrollment forms to your GIC Coordinator and the Buy-Out form to the GIC.

* See pages 21-27 for eligibility and option details.

Enrollment and application forms are available on our website – mass.gov/gic/forms – and through your GIC Coordinator.

We continue to face a challenging environment for both the state budget and controlling health care costs. Unknown Affordable Care Act changes, anticipated personal income tax decreases, and sluggish sales tax revenue may affect state and municipal revenues. At the same time, rising health care costs are crowding out other critical needs, including public safety and local aid. The state's health care increase benchmark under Chapter 224 is 3.6% annually, and this has been hard to achieve with rising costs. Yes, an aging population and mandates are contributing to rising costs, but the two main drivers are:

- High-cost providers and the prevalent use of these providers
- Skyrocketing prescription drug costs

According to the Massachusetts Center for Health Information and Analysis (CHIA), 80.3% of 2014 hospital commercial payments went to the most expensive Massachusetts hospitals. The GIC's members are also using the most expensive hospitals, with 46% of utilization in one of our largest broad network plans using Tier 3 — the most expensive — hospitals.

The GIC's winter 2017 *For Your Benefit* newsletter outlined many of the reasons for skyrocketing prescription drug costs. The Health Policy Commission reported in the fall that prescription drug costs rose 8.8% from 2014-2015 and now represent 17.2% of total Massachusetts medical expenditures.

The GIC's initial premium requests from the plans came in at 10.2% — clearly unaffordable for the state, municipalities, and members. The Commission knew that it would be able to negotiate down from this somewhat, but other changes would be needed to come in within the state's benchmark of 3.6%. Guiding principles were to:

- Spread the burden fairly
- Align benefits between plan options
- Use methods other than benefit changes to bring down trends wherever possible.

In line with the third goal, the GIC is renegotiating our contract with CVS Caremark and continues the Centered Care Initiative to encourage our health plans to move from fee-for-service provider contracts to global budgets. The GIC's Clinical Performance Improvement (CPI) Initiative that analyzes 155 million de-identified claims on nationally recognized measures of quality and/or cost efficiency will continue for Fallon Health, Health New England, Neighborhood Health Plan and the UniCare State Indemnity Plan. Members of these plans pay the lowest copay for the highest-performing specialists:

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

Harvard Pilgrim Health Plan and Tufts Health Plan will also tier providers to encourage members to shop for their care.

In a major initiative, the GIC has proposed legislation as part of the Governor's budget to cap payments to hospitals, doctors, and other providers for GIC members.

Additional benefit changes were also needed. Some of our broad network plans were spending well beyond other similar plans. These plans include Fallon Health Select Care, which proposed a 9.4% increase; Harvard Pilgrim Independence, which proposed a 6.1% increase after two consecutive years of increases exceeding 9.0%; and Tufts Health Plan Navigator, which proposed a 12.9% increase. As a result, these plans are **closed** to new members. This change and others are outlined on the next few pages.

Take Action to Lower Your Out-of-Pocket Costs

- Work with your **Primary Care Provider (PCP)** to navigate the health care system.
- Seek care from **Tier 1 and Tier 2 doctors**.
- Access on your phone or make copies and **bring the prescription drug formulary** from your plan's website with you to all doctor visits.
- If you are in a tiered hospital plan and have a planned hospital admission, talk with your doctor about whether a **Tier 1 hospital** would make sense.
- Use your **health plan's cost estimator** for health care procedure shopping — **UniCare and Fallon will send members a check** if they shop for and then visit a lower-cost provider.
- Use **urgent care facilities and retail minute clinics** instead of the emergency room for urgent (non-emergency) care.
- Enroll in **pre-tax Flexible Spending Account** benefits.
- **Eat healthy, exercise regularly, don't smoke, and find ways to de-stress.** Articles to help you take charge of your health are posted on our website: mass.gov/gic/yourhealth.

Take Advantage of Annual Enrollment

It's more important than ever to review your health plan options during this year's Annual Enrollment. Be sure to follow the **Gather, Investigate and Choose** instructions on page 3 and watch the Annual Enrollment video at mass.gov/gic/aevideo. If you are in a plan with a high premium, it's important to take the opportunity to consider enrolling in a less expensive plan (*see page 2*). The health plan in which you are currently enrolled may or may not be the best value for you and your family for the next fiscal year.

Health Plans

New Prescription Drug Fiscal Year Deductible

There will be a new separate prescription drug deductible of \$100 individual/\$200 family for all health plans except Fallon Health Direct and Select. Oral chemotherapy and preventive care medications covered under the Affordable Care Act will not be subject to the deductible.

Fiscal Year Medical Deductible

The fiscal year deductible will increase to \$500 individual/\$1,000 family (regardless of family size). For the Fallon Health Direct and Select plans, the deductible will increase to \$550 individual/\$1,100 family.

Health Plans Closed to New Members

Due to concerns about significant premium increases and spending beyond those premium rates, **Fallon Health Select Care, Harvard Pilgrim Independence Plan, and Tufts Health Plan Navigator** will be closed to new members:

- Existing members can stay in or leave these plans and can change their coverage (e.g., individual to family) within 60 days of a qualifying event; however,
- New groups or new employees joining the GIC cannot enroll in these plans;
- Individuals who are picking up GIC health insurance coverage during Annual Enrollment or within 60 days of a qualifying event cannot enroll in these plans; and
- Existing GIC members currently enrolled in other health plans cannot switch into these plans.

Medication-Assisted Treatment

There will no longer be any copayments or prior authorization for Medication-assisted Treatment for opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products). These drugs will also not be subject to the prescription drug deductible.

Harvard Pilgrim Independence and Primary Choice Plans

- The prescription drug formulary for these plans will change to a closed formulary similar to the other plans. This means certain prescription drugs will be excluded from coverage, but will have alternatives available that are more cost effective.
- Physician office visit and hospital tiering will change to one based on provider group value instead of individual performance. This could affect your copays. Contact the plan to see each of your provider's tiers for the office location you visit. Also, contact the plan to see which tier your hospital is in.

Harvard Pilgrim Independence Plan

- Will implement Primary Care Provider (PCP) tiering based on provider group value: \$10 Tier 1/\$20 Tier 2/\$40 Tier 3. Contact the plan to find out which tier your PCP is in.
- The outpatient behavioral health/substance use disorder office visit copay will decrease to \$10 per visit.
- The out-of-network deductible will increase to \$500 per individual and \$1,000 per family.

Tufts Health Plan Navigator and Spirit

- Physician office visit and hospital tiering will change to one based on provider group value instead of individual performance. This could affect your copays. Contact the plan to see each of your provider's tiers for the office location you visit. Also, contact the plan to see which tier your hospital is in.

Tufts Health Plan Navigator

- Will implement Primary Care Provider (PCP) tiering based on provider group value: \$10 Tier 1/\$20 Tier 2/\$40 Tier 3. Contact the plan to find out which tier your PCP is in.
- The outpatient behavioral health/substance use disorder office visit copay will decrease to \$10 per visit.
- The out-of-network deductible will increase to \$500 per individual and \$1,000 per family.

Unicare State Indemnity Plan/Basic and Community Choice

- The telehealth benefit already available to UniCare PLUS members will be expanded to these two plans: \$15 copay/telehealth visit.

Unicare State Indemnity Plan/Plus

- The out-of-network deductible will increase to \$500 per individual and \$1,000 per family.

Other GIC Benefit Changes

Long Term Disability

The GIC awarded a new contract to Unum to continue as the Long Term Disability carrier. The rates will go down by approximately nine percent, depending on your age. Now is a good time to consider applying. *See page 21 for more information.*

Pre-Tax Flexible Spending Accounts

- The Health Care Spending Account maximum will increase to \$2,600.
- In keeping with state statute, eligibility for the Dependent Care Assistance Program is changing. To participate, you must be eligible for GIC health insurance benefits.

See page 23 for important dates and more details on this program.

Dental/Vision

The GIC awarded a new contract to MetLife to continue as the dental carrier:

- Rates will decrease;
- The annual per-person calendar year maximum will increase to \$1,500 for in-network claims and \$1,250 for out-of-network claims;

- Preventive and diagnostic services will no longer count against the annual maximum benefit;
- Periodontal maintenance cleanings coverage will increase to 100%;
- The lifetime Orthodontic maximum will increase to \$1,500; and
- In keeping with industry standards, out-of-network claims will be reimbursed at the 90th percentile of Usual and Customary charges.

See pages 26-27 for more information.

WellMASS

The WellMASS wellness pilot program will end June 30, 2017. Wellness benefits are provided through the health plans. *See page 28 for gym membership discounts by plan.*

Keep In Mind...

Enrolling in a Health Plan: Members can only enroll in coverage for the first time as a new hire, at Annual Enrollment or within 60 days of a documented qualifying event: marriage, birth/adoption of child, involuntary loss of other coverage, spouse's annual enrollment, or return from an approved FMLA or military leave.

Changing or Canceling Health Plan Coverage: Members can only change from individual to family, family to individual, or cancel coverage during Annual Enrollment or within 60 days of a qualifying event: marriage, birth/adoption of child, change in dependent eligibility, divorce (subject to M.G.L. Ch. 32A eligibility requirements), death of spouse/dependent or spouse's or dependent's involuntary loss of coverage elsewhere.

Changing Health Plans: Members can only change health plans at Annual Enrollment, unless you move out of your health plan's service area, at retirement, or are retired and become Medicare eligible, in which case you **must** change plans.

Qualifying Status Procedures and Deadlines: See the qualifying status change document for procedures and deadlines for qualifying events: mass.gov/gic/qualifyingevents.

You MUST Notify Your GIC Coordinator When Your Personal or Family Information Changes

Failure to notify the GIC of family status changes, such as legal separation, divorce, remarriage, and/or addition of dependents **can result in financial liability** to you. Please notify your GIC Coordinator when any of the following changes occur. See the GIC's website for forms and any required documentation (mass.gov/gic/forms):

- Marriage or remarriage
- Legal separation
- Divorce
- Address change
- Birth or adoption of a child
- Legal guardianship of a child
- Remarriage of a former spouse
- 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 a covered spouse, dependent or beneficiary
- Life insurance beneficiary change
- You have GIC COBRA coverage and become eligible for other coverage



See our website for answers to other FAQs:
mass.gov/gic/faq

Q. I have GIC health insurance coverage. When must I enroll in Medicare Part A and Part B?

- A.** The answer depends on your employment status with the Commonwealth or participating GIC municipality:
- **If you, the insured, continue working** for the state or a participating GIC municipality at age 65 or over, you and your covered spouse should only enroll in free Medicare Part A if eligible. Defer Part B until you, the insured, retire.
 - **If retiring**, and you or your covered spouse is age 65 or over, the family member(s) age 65 or over should apply for Medicare Part A and Part B up to a month before your retirement. You and/or your spouse age 65 or over will receive a Medicare enrollment package from the GIC approximately two to three weeks after the GIC is notified by your GIC Coordinator of your retirement. Be sure to respond to the GIC by the due date noted in the package.

Q. I am getting married; how do I add my new spouse to my GIC health insurance coverage?

- A.** Complete the *Enrollment/Change Form (Form-1)* and include a copy of your marriage certificate. Active employees return these forms to their GIC Coordinators; retirees return them to the GIC. Forms and documentation must be received at the GIC **within 60 days of the marriage**. Otherwise, you must wait until the next Annual Enrollment to add your spouse.

Q. How can I add a newborn to my GIC coverage?

- A.** Complete the *Enrollment/Change Form (Form-1)* and attach a copy of the hospital announcement letter or your child's birth certificate. A Social Security number must be sent, but you can do so upon receipt from Social Security. The birth certificate or hospital notice must link the dependent to the insured or spouse. The GIC must receive the form and documentation **within 60 days of the birth**.

Documents and forms received after 60 days of the qualifying event will be denied and you must wait until the next Annual Enrollment to add the dependent.

Q. How do I drop a spouse or dependent from my GIC health and/or Dental/Vision coverage?

- A.** Complete an *Enrollment/Change Form (Form-1)* and attach proof of the qualifying event (e.g., enrollment in other health coverage or spouse's/dependent's open enrollment). The GIC must receive this form and documentation **within 60 days of the qualifying event**. Documents and forms received after 60 days of the qualifying event will be denied and you must wait until the next Annual Enrollment to drop the spouse/dependent from your coverage. For a death of a spouse or dependent only, if documentation is received after 60 days, the GIC will determine the effective date of cancellation and you will not need to wait for the next Annual Enrollment.

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. The Dependent Care Assistance Program (DCAP) begins on the first day of employment. Enrollment forms must be completed and returned to your GIC Coordinator within 10 calendar days of hire.

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/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, you and your family must change plans. The UniCare State Indemnity Plan/Basic is the GIC's only nationwide plan.

Medical Deductible Changes and New Prescription Drug Deductible

All GIC health plans include a deductible that applies to certain services. Before the plan will pay for these services, you are responsible for paying your provider(s) up to the deductible maximum. This is a separate charge from any copays.

- The fiscal year deductible will increase, effective July 1, 2017.
- There will be a new separate prescription drug deductible for all health plans except Fallon Health Direct and Select.

Medical Deductible Questions and Answers

Q. How much is the in-network fiscal year 2018 medical deductible?

- A.** The in-network deductible will increase effective July 1, 2017 to \$500 per individual and \$1,000 per family.

Here is how it works for each coverage level:

- **Individual:** The individual has a \$500 deductible before benefits begin.
- **Two- or more person family:** The family as a whole has a \$1,000 maximum deductible before benefits begin, but no single family member will be liable for more than \$500 per year.

If you are in Harvard Independence, Tufts Navigator, or UniCare PLUS, there is an additional out-of-network deductible. This deductible is increasing effective July 1, 2017, to \$500 per member, up to a maximum of \$1,000 per family. This is a separate charge from the in-network deductible.

Q. What is the effect of changing plans on my deductible?

- A.** There is no effect on your deductible for changing plans during Annual Enrollment. Whether you decide to stay in the same health plan, switch to a different option with the same health plan carrier, or switch to a different health plan carrier, a new deductible will begin July 1.

Q. Which health care services are subject to the medical deductible?

- A.** The lists to the right summarize expenses that generally are or 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 to the right may occur, depending upon individual patient circumstances and a plan's schedule of benefits.***

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

- Prescription drugs
- 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
- Colonoscopies

Examples of in-network expenses ***generally subject to*** the medical 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 required to tell you the amount you will be required to pay before you incur charges. Call your plan or visit their website to get this information.

When you visit a doctor or hospital, the provider should 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. Please contact your plan if you have any questions about what you owe.

Prescription Drug Deductible Questions and Answers

Q. *How much is the fiscal year 2018 prescription drug deductible?*

A. The prescription drug deductible effective July 1, 2017, will be \$100 per individual and \$200 per family for all plans except Fallon Health Direct and Select.

Q. *How does the prescription drug deductible affect my copays?*

A. If the cost of a drug is less than \$100, you will pay the cost of the drug, which will go towards satisfying the deductible. Once an individual reaches his or her deductible, copays apply. When the family deductible is reached, copay benefits apply to all family members, even those who have not met their individual deductible.

Examples:

Family Member 1 orders a 30-day supply of a brand drug that costs \$80. This family member will pay \$80 to the pharmacist and will have a \$20 deductible balance.

Family Member 2 orders a 30-day supply of a brand drug that costs \$105.23. The family member will pay the \$100 deductible **plus** the balance of \$5.23, because the remaining balance is less than the brand copay of \$30. This family member has satisfied his or her prescription drug deductible and will pay copays only for all future prescription drugs.

Family Member 3 orders a 30-day supply of a brand name drug that costs \$200. This family member will pay the remaining family deductible of \$20 (see Family Member 1) plus the \$30 copay. The family's deductible has been met and all family members will pay a copay for any prescription drugs ordered for the remainder of the fiscal year until they reach their out-of-pocket maximum.

Prescription Drug Changes Effective July 1, 2017

- GIC health plans, except for Fallon Direct and Fallon Select, will have a fiscal year deductible of \$100 individual/\$200 family. The prescription drug deductible is separate from your health plan deductible. Once you've paid your prescription deductible, your covered drugs will be subject to a copayment.
- The prescription drug program for Harvard Pilgrim Independence Plan and Harvard Pilgrim Primary Choice Plan will change to a closed formulary, similar to the other GIC plans. Certain prescription drugs will be excluded from coverage. The excluded products have alternatives available that are more cost effective.

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. 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.

Prescription Drug Programs

Most GIC plans 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 and whether they apply to drugs you are taking:

- **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 you wish to continue to use a retail pharmacy or change to 90-day supplies through either mail order or select retail pharmacies.
- **Specialty Drug Pharmacies** – If you are prescribed injected or infused specialty drugs, you may need to use a specialty pharmacy which can provide you with 24-hour clinical support, education and side effect management. Medications are delivered to your home or doctor's office.
- **Prior Authorization** – You or your health care provider may be required to contact the plan for Prior Authorization before getting certain prescriptions filled. This restriction could be in place for safety reasons or because the plan needs to understand the reasons the drug is being prescribed instead of a less expensive, first-line formulary option.
- **Quantity Limits** – To promote member safety and appropriate and cost-effective use of medications, there may be limits on the quantity of certain prescription drugs that you may receive at one time.








Tips for Reducing Your Prescription Drug Costs

During Annual Enrollment, Compare and Contrast Prescription Drug Programs: Contact the plans you are considering to find out which tier the prescription drugs you and your family use most often are in. It may save you money to switch to a plan that places your prescription drugs in a more favorable tier.

Use Mail Order: Are you taking prescription drugs for a long-term condition, such as asthma, high blood pressure, or high cholesterol? Switch your prescription from a retail pharmacy to mail order. Some plans offer this benefit at select retail pharmacies. It can save you money – \$5-\$30 for three months of medication, depending on the tier. *See the at-a-glance chart for copay details.* Once you begin mail order, you can conveniently order refills by phone or online. Contact your plan for details.

State Employee Health Plan Rates

Monthly GIC Plan Rates Effective July 1, 2017

		For Employees Hired Before July 1, 2003		For Employees Hired On or After July 1, 2003	
		20%		25%	
		Employee Pays Monthly		Employee Pays Monthly	
BASIC LIFE INSURANCE ONLY – \$5,000 Coverage		\$1.30		\$1.63	
HEALTH PLAN (Premium includes Basic Life Insurance)	PLAN TYPE	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY
Fallon Health Direct Care 	HMO	\$111.84	\$266.61	\$139.81	\$333.27
Fallon Health Select Care CLOSED TO NEW MEMBERS	HMO	148.20	353.84	185.25	442.31
Harvard Pilgrim Independence Plan CLOSED TO NEW MEMBERS	POS	165.57	402.12	206.97	502.65
Harvard Pilgrim Primary Choice Plan 	HMO	125.01	303.15	156.27	378.94
Health New England 	HMO	110.55	272.15	138.19	340.19
NHP Prime (Neighborhood Health Plan)	HMO	111.72	293.92	139.66	367.41
Tufts Health Plan Navigator CLOSED TO NEW MEMBERS	POS	146.56	355.74	183.21	444.68
Tufts Health Plan Spirit 	EPO (HMO-Type)	111.57	266.75	139.47	333.45
UniCare State Indemnity Plan/Basic with CIC* (Comprehensive)	Indemnity	245.81	572.62	295.56	688.63
UniCare State Indemnity Plan/Basic without CIC (Non-Comprehensive)	Indemnity	198.97	463.98	248.72	579.99
UniCare State Indemnity Plan/ Community Choice 	PPO-Type	105.05	250.32	131.32	312.91
UniCare State Indemnity Plan/PLUS	PPO-Type	139.46	331.37	174.33	414.22

* CIC is an enrollee-pay-all benefit.



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

Limited Network Health Plans



Limited Network Plan

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.

Specialist Tiering

Fallon Health tiers specialists based on quality and/or cost efficiency. 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.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

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.



Specialist and Hospital Tiering Changes

Harvard Pilgrim is changing its tiering program to one based on provider group value instead of individual performance.

This change may affect your copays. Members will pay lower copays for Tier 1 and Tier 2 specialists and Tier 1 hospitals. Contact the plan to find out each of your provider's tier at the office location you visit. Also contact the plan to see which tier your hospital is in.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

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.

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.

Specialist Tiering

Health New England tiers Massachusetts specialists based on quality and/or cost efficiency. 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.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

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).

The behavioral health benefits of this plan are administered by Beacon Health Options.

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.



Specialist and Hospital Tiering Changes

Tufts Health Plan is changing its tiering program to one based on provider group value instead of individual performance.

This change may affect your copays. Members will pay lower copays for Tier 1 and Tier 2 specialists and Tier 1 hospitals. Contact the plan to find out each of your provider's tier at the office location you visit. Also contact the plan to see which tier your hospital is in.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

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 at 100% coverage, after a copayment. 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 find out 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).

The behavioral health benefits of this plan, administered by Beacon Health Options, 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.

Specialist Tiering

UniCare tiers Massachusetts specialists based on quality and/or cost efficiency. 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.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.



BENEFITS AT-A-GLANCE

HEALTH PLAN COPAYS & DEDUCTIBLES

This chart is a comparative overview of GIC plan benefits. See the corresponding overview information for Community Choice and PLUS are **in-network** benefits with PCP referral where required. These plans also provide benefits for the GIC's EPO and HMOs. For a list of doctors, hospitals and other providers, benefit details, and more information, visit [tuftshealthplan.com](#).

HEALTH PLAN	FALLON HEALTH DIRECT CARE	FALLON HEALTH SELECT CARE	HARVARD PILGRIM INDEPENDENCE PLAN	HARVARD PILGRIM PRIMARY CHOICE PLAN	HEALTH NEW ENGLAND
PLAN TYPE	HMO	HMO	POS	HMO	HMO
PCP Designation Required?	Yes	Yes	Yes	Yes	Yes
PCP Referral to Specialist Required?	Yes	Yes	Yes	Yes	No
Out-of-pocket Maximum					
Individual coverage	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Family coverage	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000
Fiscal Year Deductible					
Individual	\$550	\$550	\$500	\$500	\$500
Family	\$1,100	\$1,100	\$1,000	\$1,000	\$1,000
Primary Care Provider Office Visit	\$15 per visit	\$20 per visit	Tier 1: \$10 per visit Tier 2: \$20 per visit Tier 3: \$40 per visit	\$20 per visit	\$20 per visit
Preventive Services	Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay
Specialist Physician Office Visit					
Tier 1	\$30 per visit	\$30 per visit	\$30 per visit	\$30 per visit	\$30 per visit
Tier 2	\$60 per visit	\$60 per visit	\$60 per visit	\$60 per visit	\$60 per visit
Tier 3	\$90 per visit	\$90 per visit	\$90 per visit	\$90 per visit	\$90 per visit
Retail Clinic and Urgent Care Center	\$15 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit
Outpatient Behavioral Health/Substance Use Disorder Care	\$15 per visit	\$20 per visit	\$10 per visit	\$20 per visit	\$20 per visit
Emergency Room Care	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)
Inpatient Hospital Care – Medical	Maximum one copay per person per calendar year				
Tier 1	\$275 per admission	\$275 per admission	\$275 per admission	\$275 per admission	\$275 per admission
Tier 2	\$500 per admission	\$500 per admission	\$500 per admission	\$500 per admission	\$500 per admission
Tier 3	\$1,500 per admission	\$1,500 per admission	\$1,500 per admission	No Tier 3	with no tiering
Outpatient Surgery	Maximum one copay per calendar year				
	\$250 per occurrence	\$250 per occurrence	\$250 per occurrence	\$250 per occurrence	\$250 per occurrence
High-Tech Imaging (e.g., MRI, CT and PET scans)	Maximum one copay per scan				
	\$100 per scan	\$100 per scan	\$100 per scan	\$100 per scan	\$100 per scan
Prescription Drug	Prescription Drug Deductible: N/A				
Retail, up to a 30-day supply Tier 1 / Tier 2 / Tier 3	\$10 / \$30 / \$65	\$10 / \$30 / \$65	\$10 / \$30 / \$65	\$10 / \$30 / \$65	\$10 / \$30 / \$65
Mail Order Maintenance Drugs, up to a 90-day supply Tier 1 / Tier 2 / Tier 3	\$25 / \$75 / \$165	\$25 / \$75 / \$165	\$25 / \$75 / \$165	\$25 / \$75 / \$165	\$25 / \$75 / \$165

Copays and deductibles that appear in **bold** in this chart have changed effective July 1, 2017.

Fallon Health Select Care, Harvard Pilgrim Independence Plan, and Tufts Health Plan Navigator are closed to new members. See page 6 for more information.

For each plan for more information. Benefits described below for the Harvard Pilgrim Independence Plan, Tufts Health Plan Navigator, and UniCare State Indemnity Plan/also offer out-of-network benefits with higher out-of-pocket costs. Contact the plans for details. With the exception of emergency care, there are no out-of-network exclusions, and limitations, see the plan handbook or contact the individual plan. For details about UniCare/Basic without CIC, contact the plan.

NHP PRIME (Neighborhood Health Plan)	TUFTS HEALTH PLAN NAVIGATOR	TUFTS HEALTH PLAN SPIRIT	UNICARE STATE INDEMNITY PLAN/BASIC with CIC (Comprehensive)	UNICARE STATE INDEMNITY PLAN/ COMMUNITY CHOICE	UNICARE STATE INDEMNITY PLAN/PLUS
HMO	POS	EPO (HMO-TYPE)	INDEMNITY	PPO-TYPE	PPO-TYPE
Yes	Yes	No	No	No	No
Yes	Yes	No	No	No	No
\$5,000	\$5,000	\$5,000	\$4,000 medical & behavioral health/\$1,500 Rx	\$4,000 medical & behavioral health/\$1,500 Rx	\$4,000 medical & behavioral health/\$1,500 Rx
\$10,000	\$10,000	\$10,000	\$8,000 medical & behavioral health/\$3,000 Rx	\$8,000 medical & behavioral health/\$3,000 Rx	\$8,000 medical & behavioral health/\$3,000 Rx
\$500 \$1,000	\$500 \$1,000	\$500 \$1,000	\$500 \$1,000	\$500 \$1,000	\$500 \$1,000
\$20 per visit	Tier 1: \$10 per visit Tier 2: \$20 per visit Tier 3: \$40 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$15 per visit for Centered Care PCPs; \$20 per visit for other PCPs
Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay	Most covered at 100% – no copay
\$30 per visit \$60 per visit \$90 per visit	\$30 per visit \$60 per visit \$90 per visit	\$30 per visit \$60 per visit \$90 per visit	\$30 per visit \$60 per visit \$90 per visit	\$30 per visit \$60 per visit \$90 per visit	\$30 per visit \$60 per visit \$90 per visit
\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit
\$20 per visit	\$10 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit
\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)
year quarter. Waived if readmitted within 30 days in the same calendar year.					
\$275 per admission with no tiering	\$275 per admission \$500 per admission \$1,500 per admission	\$300 per admission \$700 per admission No tier 3	\$275 per admission with no tiering	\$275 per admission with no tiering	\$275 per admission \$500 per admission \$1,500 per admission
Quarter or four per year, depending on plan. Contact the plan for details.					
\$250 per occurrence	\$250 per occurrence	\$250 per occurrence	\$250 per occurrence	\$110 per occurrence	Tier 1 and Tier 2: \$110 per occurrence; Tier 3: \$250 per occurrence
per copay per day. Contact the plan for details.					
\$100 per scan	\$100 per scan	\$100 per scan	\$100 per scan	\$100 per scan	\$100 per scan
Prescription Drug Deductible: \$100 Individual / \$200 Family					
\$10 / \$30 / \$65	\$10 / \$30 / \$65	\$10 / \$30 / \$65	\$10 / \$30 / \$65	\$10 / \$30 / \$65	\$10 / \$30 / \$65
\$25 / \$75 / \$165	\$25 / \$75 / \$165	\$25 / \$75 / \$165	\$25 / \$75 / \$165	\$25 / \$75 / \$165	\$25 / \$75 / \$165

Out-of-pocket maximums apply to medical and behavioral health benefits across all health plans. Prescription drug (Rx) benefits are included in the out-of-pocket maximums in all health plans except UniCare, which has separate in-network out-of-pocket maximums for medical/behavioral health and prescription drugs.

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.

Fallon Health Select Care is closed to new members. See page 6 for more information.

Specialist and Hospital Tiering

Fallon Health tiers Massachusetts specialists based on quality and/or cost efficiency. 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 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.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

Harvard Pilgrim Independence Plan POS

The Harvard Pilgrim Independence Plan, administered by Harvard Pilgrim Health Care, is a POS plan that provides coverage for treatment by a network of doctors, hospitals and other health care providers. Members must select a PCP to manage their care and obtain referrals to specialists to receive care at the in-network level of coverage. It also allows treatment by out-of-network providers or in-network care without a Primary Care Provider (PCP) referral, but with higher out-of-pocket costs.

The Harvard Pilgrim Independence Plan is closed to new members. See page 6 for more information.

! Primary Care Provider (PCP), Specialist, and Hospital Tiering Changes

Harvard Pilgrim is implementing PCP tiering and changing its tiering program to one based on provider group value instead of individual performance. ***This change may affect your copays.*** Members will pay lower copays for Tier 1 and Tier 2 PCPs and specialists and Tier 1 and Tier 2 hospitals. Contact the plan to see each of your provider's tiers for the office location you visit. Also, contact the plan to see which tier your hospital is in.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

NHP Prime (Neighborhood Health Plan) HMO

NHP Prime is administered by Neighborhood Health Plan. The 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.

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.

Specialist Tiering

Neighborhood Health Plan tiers Massachusetts specialists based on quality and/or cost efficiency. 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.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

Tufts Health Plan Navigator POS

Navigator by Tufts Health Plan is a POS plan that provides coverage for treatment by a network of doctors, hospitals and other health care providers. Members must select a PCP to manage their care and obtain referrals to specialists to receive care at the in-network level of coverage. It also allows treatment by out-of-network providers or in-network care without a Primary Care Provider (PCP) referral, but with higher out-of-pocket costs.

The behavioral health benefits of this plan, administered by Beacon Health Options, 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.

Tufts Health Plan Navigator is closed to new members. See page 6 for more information.

Primary Care Provider (PCP), Specialist, and Hospital Tiering Changes

Tufts Health Plan is implementing PCP tiering and changing its tiering program to one based on provider group value instead of individual performance. ***This change may affect your copays.*** Members will pay lower copays for Tier 1 and Tier 2 PCPs and specialists and Tier 1 and Tier 2 hospitals. Contact the plan to see each of your provider's tiers for the office location you visit. Also, contact the plan to see which tier your hospital is in.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

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. The plan determines allowed amounts for out-of-state providers; you may be responsible for a portion of the total charge. To avoid additional non-Massachusetts provider charges, contact UniCare to find doctors and hospitals in your area who participate in UniCare's national Anthem and Private Healthcare Systems (PHCS) network.

The behavioral health benefits of this plan, administered by Beacon Health Options, 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.

UniCare State Indemnity Plan/Basic Indemnity (Continued)

Specialist Tiering

UniCare tiers Massachusetts specialists based on quality and/or cost efficiency. 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.

Eligibility

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

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. To avoid additional non-Massachusetts provider charges, contact UniCare to find doctors and hospitals in your area who participate in UniCare's national Anthem and Private Healthcare Systems (PHCS) network.

Members are encouraged to select a Primary Care Provider (PCP) to manage their care and 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.

The behavioral health benefits of this plan, administered by Beacon Health Options, 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.

Specialist and Hospital Tiering

UniCare tiers Massachusetts specialists based on quality and/or cost efficiency. 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.

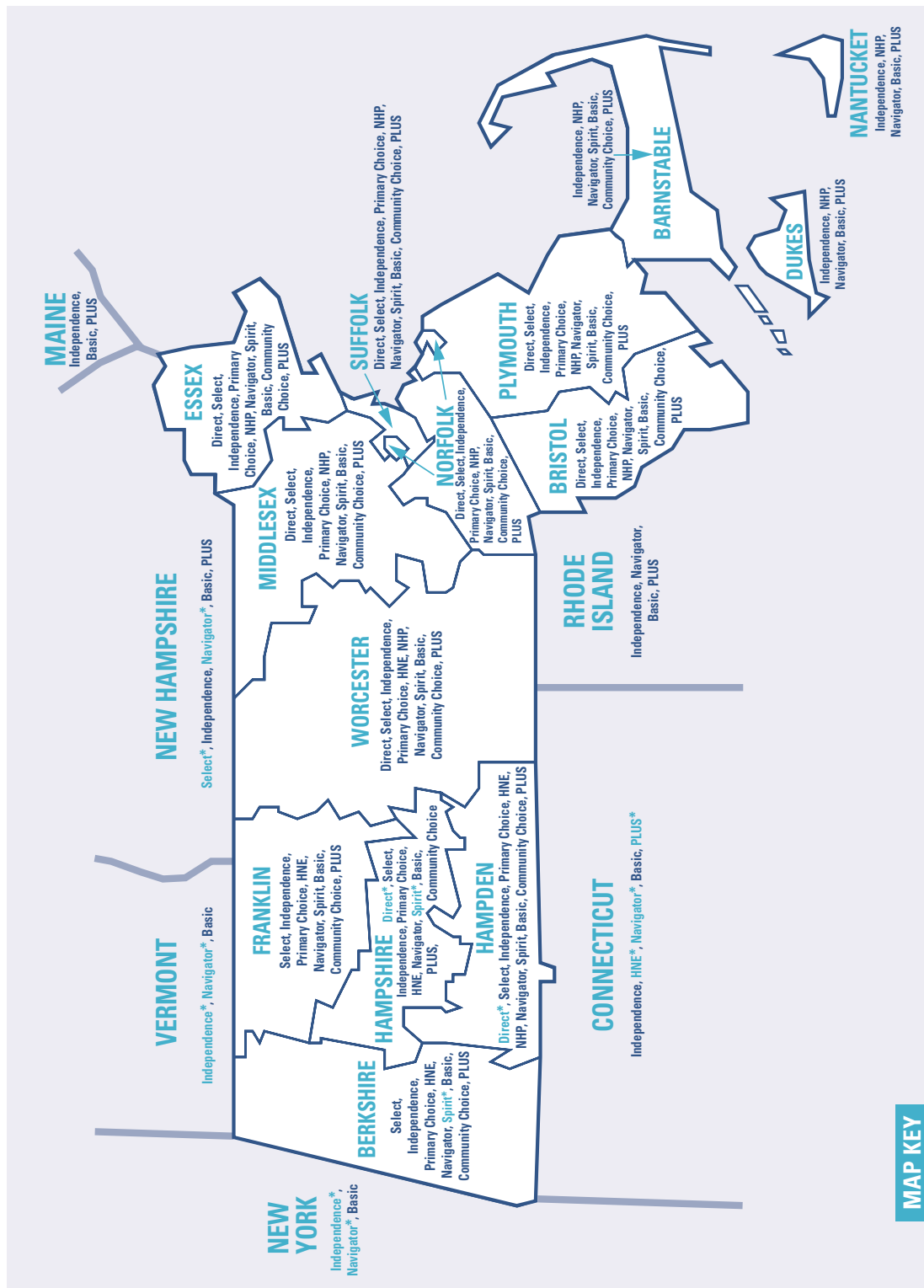
The plan also tiers hospitals based on quality and/or cost. Members pay a lower inpatient hospital and outpatient surgery copay when they use Tier 1 or Tier 2 hospitals. Contact the plan to see which tier your hospital is in.

Eligibility

Employees, Retirees, Survivors, and their eligible dependents without Medicare who live in the service area are eligible.

Health Plan Locator Map

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



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

Navigator – Tufts Health Plan Navigator
CLOSED TO NEW MEMBERS

Spirit – Tufts Health Plan Spirit

Basic – UniCare State Indemnity Plan/Basic

Community Choice – UniCare State Indemnity Plan/Community Choice

PLUS – UniCare State Indemnity Plan/PLUS

MAP KEY

Direct – Fallon Health Direct Care

Select – Fallon Health Select Care
CLOSED TO NEW MEMBERS

Independence – Harvard Pilgrim Independence Plan
CLOSED TO NEW MEMBERS

Primary Choice – Harvard Pilgrim Primary Choice Plan

HNE – Health New England

NHP – NHP Prime (Neighborhood Health Plan)

* 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 of providers in this county or state; contact the plan to find out which doctors and hospitals participate in the plan.

The GIC has selected Unum to continue as its Long Term Disability (LTD) carrier. LTD is an income replacement program that financially protects you and your family in the event you become disabled and are unable to perform the material and substantial duties of your job.

Rates Reduced Effective July 1, 2017

If you are not enrolled in LTD, now is a great time to consider applying. The rates for Long Term Disability in the rate chart reflect a nine percent decrease from last year.

LTD Benefits

If you become ill, are in an accident, or have an injury and are unable to work, it is easy to fall behind on your rent or mortgage, car payment and other expenses. With less than 25% of U.S. residents having enough savings to cover six months or more of their regular expenses (*Bankrate June 2015*), enrolling in a salary replacement plan is an important benefit for you and your family.

If you are unable to work for 90 consecutive days due to illness or injury, this program will provide participants with income replacement. Benefits include:

- A tax-free benefit of 55% of a participant's gross monthly salary, up to a maximum benefit of \$10,000 per month, up to the age of 65. If disabled on or after age 62, benefits may continue after age 65;
- A benefit for partial disabilities;
- A 36-month benefit for behavioral health disabilities;
- A rehabilitation and return-to-work assistance benefit; and
- A dependent care expense benefit.

Be sure to contact Unum within 90 days of your disability even if you are still using vacation, sick time or workers' compensation benefits. Although benefits are reduced by other income sources, such as Social Security disability, Workers' Compensation, and accumulated sick leave and retirement benefits, you will still receive a benefit. The minimum benefit will be \$100 or 10% of your gross monthly benefit amount, whichever is greater. You must notify the plan if you begin receiving other benefits.

Eligibility and Enrollment

Active state employees who are eligible for GIC benefits are eligible for LTD.

New State Employees

As a new state employee within 31 days of hire, eligible employees may enroll in LTD without providing evidence of good health.

Current State Employees

All eligible employees can apply for LTD coverage during annual enrollment, or at any time during the year. You must provide proof of good health for Unum's approval to enter the plan.

LONG TERM DISABILITY

MONTHLY GIC Plan Rates Effective July 1, 2017	
ACTIVE EMPLOYEE AGE	EMPLOYEE PREMIUM <i>Per \$100 of MONTHLY Earnings</i>
Under Age 24	\$0.08
25 – 29	0.10
30 – 34	0.14
35 – 39	0.17
40 – 44	0.35
45 – 49	0.47
50 – 54	0.57
55 – 59	0.70
60 – 64	0.67
65 – 69	0.38
70 and over	0.22



**Long Term Disability (LTD)
Questions?**
Contact Unum: 1.877.226.8620
mass.gov/gic/ltd

Health Insurance Buy-Out & Pre-Tax Premium Deductions

Health Insurance Buy-Out

If you have access to non-GIC health insurance through your spouse or another employer-sponsored plan, it may pay to participate in the Buy-Out Program.

During Annual Enrollment

If you were insured with the GIC on January 1, 2017 or before, and continue your coverage through June 30, 2017, you may apply to buy out your health plan coverage **effective July 1, 2017**, during annual enrollment.

October 2 – November 3, 2017

If you are insured with the GIC on July 1, 2017 or before, and continue your coverage through December 31, 2017, you may apply to buy out your health plan coverage **effective January 1, 2018**. The enrollment period for this buy-out will be October 2 - November 3, 2017.

In order to be eligible for the buy-out, you must have other non-GIC health insurance coverage through another employer-sponsored plan that meets Internal Revenue Service “minimum value” criteria and must maintain basic life insurance. Under the buy-out plan, eligible state employees receive 25% of the full-cost monthly premium in lieu of health insurance benefits for one 12-month period of time. Employees in HR/CMS and UMASS agencies will receive the remittance monthly in their paycheck; employees of housing and other authorities will receive a monthly check. The amount of payment depends on your health plan and coverage.

FOR EXAMPLE:

State employee with Tufts Health Plan Navigator family coverage:

Full-cost premium on July 1, 2017:	\$1,772.27
Monthly 12-month benefit =	25% of this premium
Employee receives 12 payroll deposits or monthly checks of:	\$443.05
<i>(after federal, Medicare, and state taxes)</i>	

Form Submission

Send the completed Buy-Out form to the GIC **no later than May 3, 2017** for the July 1, 2017 buyout or **November 3, 2017** for the January 1, 2018 buyout. Forms received after the deadline will not be accepted.



Buy-Out Questions?
Contact the GIC: 1.617.727.2310 ext. 1
mass.gov/gic/forms

Pre-Tax Premium Deductions

The Commonwealth normally deducts the employee’s share of basic life and health insurance premiums on a pre-tax basis. During annual enrollment, or when you have a qualified status change as outlined on the pre-tax form, you have the opportunity to change the tax status of your premiums:

- If your deductions are now taken on a pre-tax basis, you may elect to have them taxed, effective July 1, 2017.
- If you previously chose not to take the pre-tax option, you may switch to a pre-tax basis, effective July 1, 2017.



Pre-Tax Premium Deduction Questions?
Contact Your Payroll Department

The GIC's Flexible Spending Accounts (FSAs), administered by ASIFlex, help you save money on out-of-pocket health care costs and/or dependent care expenses. On average, state employees save \$300 in federal and state taxes for every \$1,000 contributed.

Health Care Spending Account (HCSA)

Through the GIC's Health Care Spending Account (HCSA), active state employees can pay for qualifying out-of-pocket health and dental care expenses on a pre-tax basis. Examples include:

- Physician office visit and prescription drug copayments
- Medical deductibles and coinsurance
- Eyeglasses, prescription sunglasses, and contact lenses
- Orthodontia and dental care
- Hearing aids and durable medical equipment
- Smoking cessation and childbirth classes
- Chiropractor and acupuncture visits

For fiscal year 2018, participants can contribute \$250 to an increased maximum of \$2,600 through payroll deduction on a pre-tax basis. Active state employees who are eligible for GIC benefits are eligible to enroll in the HCSA.

Dependent Care Assistance Program (DCAP)

The Dependent Care Assistance Program (DCAP) allows state employees to pay for qualified dependent care expenses for a child under the age of 13, a disabled child age 13 or older, and/or an adult dependent – including day care, before- and after-school programs, elder day care, and day camp – on a pre-tax basis. You may elect a tax year DCAP contribution of up to \$2,500 if married and filing separately or \$5,000 per household.

DCAP Eligibility Change Effective July 1, 2017

Effective July 1, 2017, in keeping with state statute, to participate in DCAP, you must be an active state employee and eligible for GIC benefits.

HCSA & DCAP

All HCSA participants receive two free debit cards from ASIFlex to pay for health care expenses out of their HCSA account. Additional cards for other dependents are \$5.00 per set of two cards. For DCAP participants and as an alternative for HCSA participants, pay for the expenses and then submit a claim form with receipt to receive reimbursement by check or direct deposit, depending on which option you have elected. ASIFlex has an online tool and mobile app to help expedite your claims submission. As required by the IRS, keep copies of all HCSA and DCAP receipts with your tax documents.

For the 2018 fiscal year, the monthly administrative fee for HCSA only, DCAP only, or HCSA and DCAP combined is \$2.50 on a pre-tax basis.

Key FSA Dates

2018 Fiscal Plan Year: July 1, 2017 – June 30, 2018
Open Enrollment: April 5 – May 3, 2017
2½ Month Grace Period: July 1 – September 15, 2018
Claim Filing Deadline: October 15, 2018

OPEN ENROLLMENT: April 5 – May 3, 2017

During the GIC's spring 2017 Annual Enrollment period, state employees can enroll in FSA benefits for the 12-month fiscal year of July 1, 2017 – June 30, 2018.

New State Employees and Change in Status

New state employees and employees who have a qualifying status change during the year may enroll for partial-year benefits. For HCSA, new hire benefits begin at the same time as other GIC benefits. For DCAP, coverage begins on the first day of employment.

2½ Month Grace Period

It's important to consider your election carefully. Because of the tax benefits of FSAs, the IRS imposes a strict "use-it-or-lose-it" rule, which means money left in a pre-tax account at plan year end is forfeited. However, you're given additional time with the 2½-month grace period to use your benefits. For the 2018 fiscal year, you have until **September 15, 2018** to incur claims and until **October 15, 2018** to submit claims.

Enrollment

Participants must re-enroll online each open enrollment period, and give the enrollment confirmation page to their payroll coordinator. New participants, including those enrolling due to a qualifying status change, complete and return the FSA enrollment and status change forms to your Payroll Coordinator.



HCSA and DCAP Questions?
See the FSA plan handbook
and contact ASIFlex
1.800.659.3035
asiflex.com/gic

Life insurance, insured by The Hartford Life and Accident Insurance Company, helps provide for your family's economic well-being in the event of your death. This benefit is paid to your designated beneficiaries.

Basic Life Insurance

The Commonwealth offers \$5,000 of Basic Life Insurance.

Optional Life Insurance

Optional Life Insurance is available to provide economic support for your family. This term insurance allows you to increase your coverage up to eight times your annual salary, up to a maximum of \$1.5 million. Term insurance pays your designated beneficiary in the event of your death. It is not an investment policy; it has no cash value. This is an employee-pay-all benefit.

How Much Do You Need?

To estimate how much Optional Life Insurance you might need, or whether this coverage is right for you, consider such financial factors as:

- Your family's yearly expenses;
- Future expenses, such as college tuition or other expenses unique to your family;
- Your family's income from savings, other insurance, other sources; and
- The life insurance cost and your family's outstanding debts. For instance, employees with young families and mortgages might need the coverage. But older employees who have paid off their mortgage and have no dependent expenses might not need it, especially because premiums increase significantly as you age.

Preparing for Retirement

Before retirement, you should review the amount of your Optional Life Insurance coverage and its cost to determine whether it will make economic sense for you to keep it or reduce your amount of coverage. Talk with a financial advisor about other programs that might be more beneficial at retirement. If you make no change to your optional life coverage at retirement, you will be responsible for the retiree optional life insurance premium, which can be substantial. Optional Life Insurance rates significantly increase when you retire, and continue to increase based on your age.

See the GIC Benefit Decision Guide for Retirees & Survivors or our website for these rates.



Life Insurance and AD&D Questions?
Contact the GIC: 1.617.727.2310 ext. 1
mass.gov/gic/life

Accidental Death & Dismemberment (AD&D) Benefits

In the event you are injured or die as a result of an accident while insured for life insurance, there are benefits for the following losses:

- Life
- Hands, Feet, Eyes
- Speech and/or Hearing
- Thumb and Index Finger of the Same Hand
- Quadriplegia
- Paraplegia
- Hemiplegia
- Coma
- Brain Damage
- Added benefits for loss of life in a car accident while using an airbag or seat belt

Accelerated Death Benefit

This one-time benefit allows you to elect an advance payment of 25% to 80% of your life insurance death benefit if you have been diagnosed with a terminal illness. Insured employees are eligible for this benefit if the attending physician provides satisfactory evidence that you have a life expectancy of 12 months or less. Upon payment of the accelerated death benefit, future life insurance premiums are waived, regardless of your age. The remaining balance is paid to your beneficiary when you die.

Optional Life Insurance Enrollment

You must be enrolled in Basic Life Insurance in order to apply for Optional Life Insurance.

New State Employees

As a new state employee, you may enroll in Optional Life Insurance for a coverage amount of up to eight times your salary, without the need for any medical review.

Current Employees During the Year

State employees actively at work may apply for the first time or apply to increase their coverage at any time during the year. After you apply, you will receive instructions for completing a personal health application for The Hartford's review and approval. The GIC will determine the effective date if The Hartford approves the application.

Current Employees with a Qualified Family Status Change

State employees actively at work who have a qualified family status change during the year may enroll in or increase their coverage without any medical review in an amount up to a coverage limit not to exceed four times their salary ***provided that the GIC receives proof within 31 days of the qualifying event.*** Family status changes include the following events:

- Marriage
- Birth or adoption of a child
- Divorce
- Death of a spouse

Optional Life Insurance Non-Smoker Benefit

At initial enrollment or during annual enrollment, if you have been tobacco-free (have not smoked cigarettes, cigars or a pipe nor used snuff, chewing tobacco or a nicotine delivery system) for at least the past 12 months, you are eligible for reduced non-smoker Optional Life Insurance rates. You will be required to periodically recertify your non-smoking status in order to qualify for the lower rates. Changes in smoking status made during annual enrollment will become effective July 1, 2017.

Life Insurance and Leaving State Service

Active employees who leave state service can take advantage of the following options:

- **Portability** – continue your basic and/or optional life insurance at the group rate. Eligibility for portability ends at normal Social Security retirement age.
- **Conversion** – convert your life insurance coverage to a non-group policy.



**Portability and Conversion Questions?
Contact The Hartford
1.877.320.0484**

OPTIONAL LIFE INSURANCE

Including Accidental Death & Dismemberment

MONTHLY GIC Plan Rates Effective July 1, 2017

ACTIVE EMPLOYEE AGE	SMOKER RATE <i>Per \$1,000 of Coverage</i>	NON-SMOKER RATE <i>Per \$1,000 of Coverage</i>
Under Age 35	\$0.10	\$0.04
35 – 44	0.12	0.05
45 – 49	0.20	0.07
50 – 54	0.33	0.14
55 – 59	0.53	0.21
60 – 64	0.79	0.31
65 – 69	1.45	0.70
70 and over	2.57	1.16



**Life Insurance and AD&D Questions?
Contact the GIC: 1.617.727.2310 ext. 1
mass.gov/gic/life**

GIC Dental/Vision Plan

For Managers, Legislators, Legislative Staff, and Certain Executive Office Staff

Eligibility for the GIC Dental and Vision Plan

The GIC Dental/Vision Plan is for state employees who are not covered by collective bargaining or do not have another Dental and/or Vision Plan through the state. The plan primarily covers managers, Legislators, Legislative staff, and certain Executive Office staff. Employees of authorities, municipalities, higher education, and the Judicial Trial Court system are **not** eligible for GIC Dental/Vision coverage.

Enrollment

During annual enrollment or within 60 days of a qualifying status change, eligible employees may enroll in GIC Dental/Vision. During annual enrollment, current participants may change their dental plan selection.

Dental Benefits

The GIC has selected Metropolitan Life Insurance Company (MetLife) to continue as its carrier for the dental portion of the GIC Dental/Vision Plan.

There are two dental plan options:

- **The PPO Plan** (also known as the MetLife Value Plan), and
- **The Indemnity Plan** (also known as the MetLife Classic Plan).

Both plans include MetLife's network of dentists and offer the following in-network benefits:

- 100% coverage for preventive and diagnostic services
- 80% coverage for basic services, such as root canals and extractions
- 50% coverage for major services, such as dental implants

Benefit Enhancements and Changes Effective July 1, 2017

- Rates are decreasing (see rate chart on the next page);
- Reimbursement for preventive and diagnostic services will not accumulate against the annual maximum benefit – your annual maximum will now be able to be used exclusively on more extensive services;
- Periodontal maintenance cleanings coverage will increase to 100%;
- The lifetime Orthodontic maximum will increase to \$1,500;
- The annual per-person calendar year maximum will increase to \$1,500 for in-network claims and \$1,250 for out-of-network claims; and
- In keeping with industry standards, out-of-network claims will be reimbursed at the 90th percentile of Usual and Customary charges.



Weigh Your Dental Plan Options

With either dental plan, if you use MetLife's network of participating dentists, you will be able to take advantage of negotiated fees, even after you have exceeded your annual maximum.



The GIC recommends that you check to see whether you and/or your dependents receive all of your dental care from a participating MetLife dentist:

• PPO Plan (MetLife Value):

If you and/or your dependents receive all of your care from a participating MetLife dentist, this plan will help you save on monthly premium costs and will also usually lower out-of-pocket costs. However, if you are in the PPO (MetLife Value) Plan and you go out of network, you will need to satisfy a \$100 deductible and the benefit levels are slightly lower.

• Indemnity Plan (MetLife Classic):

If you and/or your dependents intend to not visit participating dentists, choosing this plan will provide higher benefit levels, but at a higher monthly premium cost.

Keep in mind that once you choose a dental plan, you may not change plans until the next annual enrollment, even if your dentist leaves the plan during the year.



Dental Questions?

including frequency of covered services, out-of-network benefits, and providers

Contact MetLife: 1.866.292.9990
metlife.com/gic

Vision Benefits

Davis Vision is the vision provider for the vision portion of the GIC Dental/Vision Plan. This plan provides a preferred provider network of almost 2,100 Massachusetts providers, with additional providers across the country. Members receive basic services every 24 months (age 19-60) or every 12 months (age 18 or under and 61 or over) at no cost:

- Routine eye examinations
- Fashion and designer frames
- Lenses
- Scratch-resistant lens coating

Premier collection frames are covered at any of the almost 700 nationwide Visionworks stores with no copay. Non-plan frames are covered up to \$149.95 at Visionworks.

Enhanced materials and services at all preferred providers are covered at 100% after a copay. Members can also take advantage of Davis Vision discounts on additional eyewear. When members do not use a preferred provider, they are reimbursed according to a fixed schedule of benefits.



Vision Questions?

including copayment amounts,
providers, and discount programs

Contact Davis Vision: 1.800.650.2466

davisvision.com

(client code: 7852)

GIC DENTAL/VISION PLAN

MONTHLY GIC Plan Rates Effective July 1, 2017

PLAN	INDIVIDUAL COVERAGE	FAMILY COVERAGE
PPO (Value) Plan	\$4.45	\$13.80
Indemnity (Classic) Plan	5.95	18.46

The GIC’s health plans offer the following gym membership reimbursements. Contact the individual health plan (*see page 31*) to find out what other services may be covered under this program, whether the reimbursement is on a fiscal or calendar year, other wellness programs, and to get a gym membership reimbursement form.

HEALTH PLAN	ANNUAL GYM MEMBERSHIP REIMBURSEMENT
Fallon Health Direct Care	\$200 individual / \$400 family
Fallon Health Select Care	\$100 individual or family
Harvard Pilgrim Independence Plan	\$100 individual or family
Harvard Pilgrim Primary Choice Plan	\$200 individual / \$400 family
Health New England	\$150 individual or family
Neighborhood Health Plan	\$150 individual / \$300 family
Tufts Health Plan Navigator and Spirit	\$150 individual or family
UniCare State Indemnity Plan/Basic, Community Choice and PLUS	\$100 individual or family

Attend a Health Fair

Employees who are enrolling in GIC benefits for the first time, thinking about changing health plans, or are looking at other benefit options 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;
- Change your health plan or apply for other GIC active state employee benefits; and
- Take advantage of complimentary health screenings.

See page 30 for the schedule.

ADA Accommodations

If you require disability-related accommodations, contact the GIC's ADA Coordinator at least two weeks prior to the fair you wish to attend:

Tel: 1.617.727.2310

Email: GIC.ADA.Requests@massmail.state.ma.us

INSCRIPCIÓN ANUAL

La inscripción anual es del 5 de abril al 3 de mayo, y los cambios entrarán en vigor el 1 de julio de 2017. Comuníquese con Group Insurance Commission (Comisión de Seguros de Grupo) llamando al **1.617.727.2310**, ext. 1 para obtener ayuda.

年度投保

年度投保的時間為 2017 年 5 月 4 日至 3 月 5 日，變更則於 7 月 1 日生效。如需協助，請聯絡團體保險委員會 (GIC)，電話 **1.617.727.2310** 轉分機 1。

Thời gian ghi danh hàng năm

Thời gian ghi danh hàng năm là từ ngày 5 tháng 4 đến ngày 3 tháng 5 và những thay đổi sẽ có hiệu lực kể từ ngày 1 tháng 7 năm 2017. Vui lòng liên lạc với GIC tại số **1.617.727.2310**, số nội bộ là 1, để được trợ giúp.



Our Website Provides Additional Helpful Information

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;
- 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 *Turning Age 65 Q&A* brochure and *For Your Benefit* newsletters;
- Summary of Benefits and Coverage for all GIC health plans;
- Benefits At-A-Glance charts for behavioral health and substance abuse benefits for all UniCare State Indemnity plans, Tufts Health Plan Navigator and Spirit plans; and
- Health articles and links to help you take charge of your health.

APRIL 2017

7 FRIDAY 11:00 – 2:00

Berkshire Community College

Paterson Field House
1350 West Street
PITTSFIELD

8 SATURDAY 10:00 – 2:00

Mass Maritime Academy

Gymnasium
101 Academy Drive
BUZZARDS BAY

12 WEDNESDAY 11:00 – 3:00

Quinsigamond Community College

Harrington Learning Center, Rooms 109 AB
670 West Boylston Street
WORCESTER

13 THURSDAY 11:00 – 4:00

Hingham Middle School Gym

1103 Main Street
HINGHAM

14 FRIDAY 11:00 – 4:00

Northern Essex Community College

David Hartleb Technology Center
100 Elliott Street
HAVERHILL

18 TUESDAY 11:00 – 3:00

Massasoit Conference Center

770 Crescent Street
BROCKTON

19 WEDNESDAY 11:00 – 3:00

State Transportation Building

Conference Rooms 1, 2, 3
10 Park Plaza, 2nd Floor
BOSTON

20 THURSDAY 11:00 – 3:00

Wrentham Developmental Center

Graves Auditorium
Littlefield Street
WRENTHAM

21 FRIDAY 11:00 – 3:00

Middlesex Community College

Cafeteria
591 Springs Road
BEDFORD

22 SATURDAY 10:00 – 2:00

North Shore Community College

Frederick Berry Building, 1st Floor Lobby
1 Ferncroft Road
DANVERS

25 TUESDAY 10:00 – 3:00

McCormack State Office Building

1 Ashburton Place, 21st Floor
BOSTON

26 WEDNESDAY 11:00 – 3:00

Hampden County Sheriff's Department

Hampden County Correctional Center
627 Randall Road
LUDLOW

27 THURSDAY 10:00 – 2:00

UMass Amherst

Student Union Ballroom
AMHERST



**Commonwealth of Massachusetts
Group Insurance Commission**

*Your
Benefits
Connection*

For More Information, Contact the Plans

For more information about specific plan benefits, contact the individual plan. Be sure to indicate you are a GIC insured.

HEALTH INSURANCE		
Fallon Health Direct Care Select Care	1.866.344.4442	fallonhealth.org/gic
Harvard Pilgrim Health Care Independence Plan Primary Choice Plan	1.800.542.1499	harvardpilgrim.org/gic
Health New England	1.800.842.4464	hne.com/gic
Neighborhood Health Plan NHP Prime	1.866.567.9175	nhp.org/gic
Tufts Health Plan Navigator Spirit • Behavioral Health/Substance Abuse and EAP (<i>Beacon Health Options</i>)	1.800.870.9488	tuftshealthplan.com/gic
	1.855.750.8980	beaconhealthoptions.com/gic
UniCare State Indemnity Plan/ Basic Community Choice PLUS • Prescription Drugs (<i>CVS Caremark</i>) • Behavioral Health/Substance Abuse and EAP (<i>Beacon Health Options</i>)	1.800.442.9300	unicarestateplan.com
	1.877.876.7214 1.855.750.8980	caremark.com/gic beaconhealthoptions.com/gic
OTHER BENEFITS		
Health Care Spending Account (HCSA) and Dependent Care Assistance Program (DCAP) (<i>ASIFlex</i>)	1.800.659.3035	asiflex.com/gic
Life/AD&D Insurance (<i>The Hartford</i>) – Contact the GIC	1.617.727.2310 ext. 1	mass.gov/gic/life
Long Term Disability (<i>Unum</i>)	1.877.226.8620	mass.gov/gic/ltd
FOR MANAGERS, LEGISLATORS, LEGISLATIVE STAFF, AND CERTAIN EXECUTIVE OFFICE STAFF		
Dental Benefits (<i>MetLife</i>)	1.866.292.9990	metlife.com/gic
Vision Benefits (<i>Davis Vision</i>)	1.800.650.2466	davisvision.com (client code: 7852)
ADDITIONAL RESOURCES		
Employee Assistance Program for Managers and Supervisors (<i>Beacon Health Options</i>)	1.855.750.8980	beaconhealthoptions.com/gic
Internal Revenue Service (<i>IRS</i>)	1.800.829.1040	irs.gov
Social Security Administration	1.800.772.1213	ssa.gov
State Board of Retirement	1.617.367.7770	mass.gov/retirement

OTHER QUESTIONS?

Call the GIC: 1.617.727.2310, ext. 1, TDD/TTY 711
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. 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. CIC increases the benefits for most covered services to 100%, subject to deductibles and copayments. It is a Commonwealth of Massachusetts enrollee-pay-all benefit. Enrollees without CIC receive only 80% coverage for some services and pay higher deductibles. Over 99% of current Indemnity Plan Basic members select CIC.

Copayment – a set dollar amount you pay for network doctors' office visits, prescription drugs, inpatient hospital care, outpatient surgery, and emergency room care.

CPI (Clinical Performance Improvement) Initiative – under this program, which applies to members of Fallon Health, Health New England, Neighborhood Health Plan and the UniCare State Indemnity Plan, claims data from the 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.

DCAP (Dependent Care Assistance Program) – a pre-tax benefit that allows participants to set aside a certain amount of their income annually to use to pay certain employment-related dependent care expenses, such as child care or day camp for a dependent child under the age of 13 and/or a disabled adult dependent.

Deductible – a set dollar amount you are responsible for paying to your provider(s) for certain services before the plan will pay for these services. Deductibles reset each fiscal year.

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. Selection of a Primary Care Provider (PCP) is encouraged.

HCSA (Health Care Spending Account) – a pre-tax benefit that allows state employees to contribute a set amount of their income for out-of-pocket health care expenses, such as copayments, deductibles, eyeglasses and orthodontia.

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. Selection of a Primary Care Provider (PCP) is required.

Limited Network Plan – a less expensive health plan that offers essentially the same benefits as more expensive, wider network plans, but with fewer physicians, hospitals, and other providers.

LTD (Long Term Disability) – an income replacement program for active employees providing a tax-free benefit of up to 55% of salary if illness or injury renders them unable to work for longer than 90 days. Employees pay 100% of the premium.

Network – 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 a higher level of benefits when you are treated by network providers.

Out-of-Pocket Maximum – the maximum amount of medical, prescription drug, and behavioral health copays, coinsurance, and deductibles a member will pay for covered expenses within a fiscal year.

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.

Portability – allows active employees who end employment with the Commonwealth to continue life insurance coverage at the same level of coverage. The premium for the portable life insurance coverage will be at the same rates you are insured for under the Commonwealth's group plan. Certain coverage and time limits apply.

POS (Point of Service) – a health plan that provides coverage for treatment by a network of doctors, hospitals and other health care providers. Selection of a Primary Care Provider (PCP) is required. To get the lowest out-of-pocket cost, a member must get a referral to a specialist.

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

Preventive Services – health care services that do not treat an illness, injury or a condition (e.g., routine physicals).



**Commonwealth of Massachusetts
Group Insurance Commission**

P.O. Box 8747
Boston, MA 02114

COMMONWEALTH OF MASSACHUSETTS

Charles D. Baker, *Governor*
Karyn Polito, *Lieutenant Governor*

Group Insurance Commission
Roberta Herman, M.D., *Executive Director*
19 Staniford Street, 4th Floor
Boston, Massachusetts

Telephone: 617.727.2310
TDD/TTY: 711

Mailing Address

Group Insurance Commission
P.O. Box 8747
Boston, MA 02114

Website
mass.gov/gic

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Valerie Sullivan (*Public Member*)
Margaret Thompson (*Local 5000, S.E.I.U., NAGE*)