Central & Western Massachusetts 2017	*Blue Cross Blue Shield of Massachusetts 1-800-678-2265*									
	Medicare HMO Blue ValueRx	**Medicare HMO Blue PlusRx**	**Medicare PPO Blue SaverRx**		**Medicare PPO Blue PlusRx**		**Medicare PPO Blue ValueRx**		**Medicare HMO Blue FlexRx (HMO POS)**	
Plan Number	H2261-019	H2261-005	H2230-017		H2230-002		H2230-016		H2261-021	
Berkshire										
Franklin	$39	$295	$0		$230		$79		$99	
Hampden	$39	$295	$0		$230		$79		$99	
Hampshire	$39	$295	$0		$230		$79		$99	
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Health Plan Deductible	None	None	None	None	None	None	None	None	None	None
PCP	$20	$15	$25	$25	$15	$45	$20	$20	$15	$65
Specialist	$40	$35	$45	$45	$35	$45	$40		$35	$65
Inpatient Hospital	$275/day (days 1-5) $0/day (after day 5) per admis/ no annual OOP max	$150/ day (days 1-5) $0/ day(after day 5) per admis/ no annual OOP	$350/day (days 1-5) $0/day (after 5/days)per admis/no annual OOP maximum	$350/day (days 1-5) $0/day (after 5/days)per admis/no annual OOP maximum	$150/day (days 1-5) $0/ day (after 5 days) per admis/ no annual OOP	20% Co-ins	$250/day (days 1-5) $0/day (after day 5) Per admission	$250/day (days 1-5) $0/day (after day 5) Per admission	$200 (days 1-5) $0/ day (after 5 days) per admis/ no annual OOP	20% Co-ins
Outpatient Services/Surgery	Ambulatory $250/visit	Ambulatory: $150/visit	$300/visit	$300/visit	Ambulatory:- $150/visit	20% Co-ins	$225/visit	$225/visit	Ambulatory:- $200/visit	20% Co-ins
Outpatient Rehab	$20/ visit	$15/visit	$40/visit	$40/visit	$15/visit	20% Co-ins	$20/visit	$20/visit	$15/visit	20% Co-ins
Diagnostic Tests and Labs	$30/day Labs and tests, $20/day X-Rays $250/day High Tech Imaging	$10/day Labs& Diag tests, $10/day X-Rays $150/day High Tech Imaging	$30/day Labs & Diag tests $30/day X-Rays $325/day High Tech Imaging $60/visit Radiologic Serv	$30/day Labs & Diag tests $30/day X-Rays $325/day High Tech Imaging $60/visit Radiologic Serv	$10/day Labs $10 Tests, X-Rays $150/day High Tech Imaging	20% Co-ins tests and labs, 40% high tech imaging	$20/day labs $20 /day tests and xrays, $250/day High Tech imaging	$20/day labs $20 /day tests and xrays, $250/day High Tech imaging	$15/day Labs & Diag tests $15/day X-Rays $200/day High Tech Imaging	20% Co-ins tests and labs, 40% high tech imaging
Skilled Nursing/Per benefit Period	$0/day (days 1-20) $160/day (days 21-44) $0/day (days 45-100)	$20/day (days 1-20) $100/day (days 21-44) $0/day (days 45-100)	$0/day (days 1-20) $160/day (days 21-44) $0/day (days 45-100)	20% Co-ins	$20/day (days 1-20) $100/day (days 21-44) $0/day (days 45-100)	20% Co-ins	$0/day (days 1-20) $160/day (days 21-44) $0/day (days 45-100)	20% Co-ins	$0/day (days 1-20) $140/day (days 21-44) $0/day (days 45-100)	20% Co-ins
Emergency Room	$75	$75	$75	$75	$75	$75	$75	$75	$75	$75
Ambulance	$100/trip	$100/trip	$250/trip	$250/trip	$100/trip	$100/trip	$100/trip	$100/trip	$100/trip	$100/trip
DME	20%	10%	20%	20%	10%	20% Co-ins	20%	20%	10%	20% Co-ins
Diabetic Supplies	$0	$0	$0	$0	$0	20% Co-ins	$0	$0	$0	20% Co-ins
Part B Medications	15%	10%	20%	20%	10%	10%	15%	15%	10%	10%
Annual Maximum	$4,900	$3,400	$6,700		$3,400	$5,100 combined	$4,900		$3,900 in network	$9,900 out of network
Drug Deductible	$320 on Tiers 3-5	$200 on Tiers 3-5	$400 on tiers 3-5		$200 on tiers 3-5		$320 on tiers 3-5		$260 on tiers 3-5	
Drug Co-pays Tier 1	$4	$2	$6		$2		$4		$2	
Tier 2	$8	$6	$12		$6		$8		$6	
Tier 3	$45	$45	$45		$45		$45		$45	
Tier 4	$95	$95	$95		$95		$95		$95	
Tier 5	26%	25%	25%		25%		26%		26%	
Gap Generic Coverage	No	No	No		No		No		No	
Vision (Yes/No)	Yes	Yes	No		Yes		Yes		Yes	No
Hearing (Yes/no)	Yes	Yes	No		Yes		Yes		Yes	Yes
Dental (Yes/No)	Yes	Yes	Yes		Yes		Yes		Yes	Yes

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For official plan details, consult the plan's Summary of Benefits

Central & Western Massachusetts 2017	*Fallon Community Health Plan 1-888-377-1980*									
	FSP Super Saver Rx HMO	**FSP Saver HMO**	**FSP Saver Enhanced RX HMO**	**FSP Standard HMO**	**FSP Enhanced RX HMO**	**FSP Plus Enhanced RX HMO**	**FSP Plus Enhanced HMO-POS**		**FSP Saver Enhanced RX HMO-POS**	
Plan Number	H9001-032	H9001-029	H9001-030	H9001-001	H9001-015	H9001-031	H9001-033		H9001-013	
Berkshire										
Franklin	$0	$69	NA	$142	$190	$247	NA		$82	
Hampden	$0	$0	$34	NA	NA	NA	$120		NA	
Hampshire	$0	$0	$34	NA	NA	NA	$120		NA	
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Health Plan Deductible	None	None	None	None	None	None	None		None	
PCP	$20	$25	$25	$15	$15	$10	$10		$25	
Specialist	$45	$40	$40	$30	$30	$20	$20		$40	Not Covered
Inpatient Hospital	Days 1-5 $360/day	$275/day days 1-5	$275/day days 1-5	$160/ day days 1-5	$160/ day days 1-5	$200/ stay/Separate $400 out-of-pocket maximums	$200/stay separate $400 out-of-pocket maximum for acute and rehab	$600 per each stay	$275/day days 1-5	$325/day days 1-5
Outpatient Services/Surgery	Ambulatory: $300 Hospital: $300	Ambulatory: $275 Hospital: $275	Ambulatory: $275 Hospital: $275	Ambulatory: $160 Hospital: $160	Ambulatory: $160 Hospital: $160	Ambulatory: $100 Hospital: $100	$100	$200	$275	$325
Outpatient Rehab	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $15	Occupational, Physical and Speech/language therapy visit $15		Occupational, Physical and Speech/language therapy visit $20	
Diagnostic Tests and Labs	$0 for clinical/diagnostic lab services and radiation therapy. $200 for each CT, PET and MRI scan and nuclear study	$0 for clinical/diagnostic lab services and radiation therapy. $175 for each CT, PET and MRI scan and nuclear study ($700 OOPM)	$0 for clinical/diagnostic lab services and radiation therapy. $175 for each CT, PET and MRI scan and nuclear study ($700 OOPM)	$0 for clinical/diagnostic lab services and radiation therapy. $150 for each CT, PET and MRI scan and nuclear study ($600 OOPM)	$0 for clinical/diagnostic lab services and radiation therapy. $150 for each CT, PET and MRI scan and nuclear study ($600 OOPM)	$0 cor clinical/diagnostic lab services and radiation therapy. $125 for each Ct, PET and MRI scan and nuclear study ($500 OOPM)	$0 for clinical/diagnostic lab services and radiation therapy. $125 for each CT, PET and MRI scan and nuclear study ($500 OOPM)	$0 for clinical diagnostic lab services. 20% for each CT, PET and MRI scan, nuclear study, x-rays and therapeutic radiology.	$0 for clinical/diagnostic lab services. $175 for each CT, PET and MRI scan and nuclear study ($700 OOPM)	$0 for clinical/diagnostic lab services. 20% of the cost for each CT, PET and MRI scan, nuclear study, x-rays and therapeutic radiology
Skilled Nursing/Per benefit Period	$0 per day days 1-20; $160 per day days 21-44;$0 per days 45-100	$0 per day days 1-20; $150 per day days 21-44; $0 per days 45-100	$0 per day days 1-20; $150 per day days 21-44;$0 per days 45-100	$0 per day days 1-20; $100 per day days 21-44;$0 per days 45-100	$0 per day days 1-20; $100 per day days 21-44;$0 per days 45-100	$15 day days 1-20; $75 per day days 21-44; $0 per days 45-100	$15 day days 1-20; $75 per days 21-44; $0 per days 45-100		$0 per day days 1-20; $150 per day days 21-44;$0 per days 45-100	
Emergency Room	$75 copay	$75 copay	$75 copay	$75 copay	$75 copay	$75 copay	$75 copay		$75 copay	
Ambulance	$250	$175/$700 OOPM	$175/$700 OOPM	$100/$400 OOPM	$100/$400 OOPM	$75/$300 OOPM	$75/$300 OOPM		$75/$700 OOPM	
DME	20%	20%	20%	15%	15%	10%	10%		20%	
Diabetic Supplies	$0	$0	$0	$0	$0	$0	$0		$0	
Part B Medications	20%	20%	20%	15%	15%	10%	10%	20%	20%	
Annual Maximum	$6,700	$6,700	$6,700	$6,700	$6,700	$3,400	$3,400	$5,000	$5,000	
Drug Deductible	$400	N/A	$300 Tiers 3-5	NA	$200 Tiers 3-5	NA	NA		$300 Tiers 3-5	
Drug Co-pays Tier 1	Pref $2/Non Pref $7	NA	Pref $1/Non-Pref $6	NA	Pref $1/Non-Pref $6	Pref $1/Non-Pref $6	Pref $1/Non-Pref $6		Pref $1/Non-Pref $6	
Tier 2	Pref $7/Non-Pref $12	NA	Pref $6/Non-Pref $11	NA	Pref $6/Non-Pref $11	Pref $6/Non-Pref $11	Pref $6/Non-Pref $11		Pref $6/Non-Pref $11	
Tier 3	Pref $42/Non-Pref $47	NA	Pref $32/Non-Pref $37	NA	Pref $32/Non-Pref $37	Pref $32/Non-Pref $37	Pref $32/Non-Pref $37		Pref $32/Non-Pref $37	
Tier 4	Pref $95/Non-Pref $100	NA	Pref $86/Non-Pref $91	NA	Pref $86/Non-Pref $91	Pref $86/Non-Pref $91	Pref $86/Non-Pref $91		Pref $86/Non-Pref $91	
Tier 5	25%	NA	27%	NA	29%	33%	33%		27%	
Gap Generic Coverage	No	No	No	No	No	No	No		No	No
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Hearing (Yes/no)	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Dental (Yes/No)	No	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes

FALLON PREFERRED PHARMACIES
1) CVS; 2) Target; 3) Wal-Mart; 4) Big Y; 5) Shaws; 6) Stop & Shop; 7)Leader Drug stores (approximately 35 independent pharmacies across Massachusetts)

Updated 12/6/2016

Central & Western Massachusetts 2017	*Tufts Health Plan Medicare Preferred HMO 1-866-974-0118*					
	TMP Basic Rx HMO	**TMP Value No Rx HMO**	**TMP Value Rx HMO**	**TMP Prime No Rx HMO**	**TMP Prime Rx HMO**	**TMP Prime Rx+ HMO**
Plan Number	H2256-026	H2256-019	H2256-018	H2256-016	H2256-015	H2256-001
Berkshire						
Franklin						
Hampden	$9	$27	$55	$57	$85	$119
Hampshire	$9	$27	$55	$57	$85	$119
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**
Health Plan Deductible	None	None	None	None	None	None
PCP	$10	$10	$10	$10	$10	$10
Specialist	$30	$20	$20	$15	$15	$15
Inpatient Hospital	days 1–5: $275/day	days 1–5: $200/day	days 1–5: $200/day	$300 copay per vist up to $900 per year	$300 copay per vist up to $900 per year	$200 copay per vist up to $400 per year
Outpatient Services/Surgery	Ambulatory: $250 Hospital: $250	Ambulatory: $150 Hospital: $150	Ambulatory: $150 Hospital: $150	Ambulatory: $75 Hospital: $75	Ambulatory: $75 Hospital: $75	Ambulatory: $75 Hospital: $75
Outpatient Rehab	$30/visit	$20/visit	$20/visit	$15/visit	$15/visit	$15/visit
Diagnostic Tests and Labs	$10: Labs,Tests, & X-Rays $0: Therapeutic Radiology $250/day: Diagnostic Radiology	$5: Labs,Tests, & X-Rays $0: Therapeutic Radiology $100/day: Diagnostic Radiology	$5: Labs,Tests, & X-Rays $0: Therapeutic Radiology $100/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology
Skilled Nursing/Per benefit Period	days 1–20 $20/day days 21–44 $140/day days 45–100 $0	days 1–20 $20/day days 21–44 $100/day days 45–100 $0	days 1–20 $20/day days 21–44 $100/day days 45–100 $0	days 1–20 $20/day days 21–44 $60/day days 45–100 $0	days 1–20 $20/day days 21–44 $60/day days 45–100 $0	days 1–20 $20/day days 21–100 $0
Emergency Room	$75	$75	$75	$75	$75	$75
Ambulance	$275	$200	$225	$100	$110	$90
DME	20%	10%	10%	10%	10%	10%
Diabetic Supplies	$0	$0	$0	$0	$0	$0
Part B Medications	$0	$0	$0	$0	$0	$0
Annual Maximum	$3,400	$3,400	$3,400	$3,400	$3,400	$3,400
Drug Deductible	$300 (Tier 3, Tier 4, Tier 5)	N/A	$250 (Tier 3, Tier 4, Tier 5)	N/A	None	None
Drug Co-pays Tier 1	$4		$4		$4	$2
Tier 2	$8		$8		$8	$4
Tier 3	$47		$47		$47	$30
Tier 4	$100		$100		$100	$80
Tier 5	27%		28%		33%	33%
Gap Generic Coverage	No		No		No	Yes, T1 and T2
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes
Hearing (Yes/no)	Yes	Yes	Yes	Yes	Yes	Yes
Dental (Yes/No)	Optional	Optional	Optional	Optional	Optional	Optional

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Central & Western Massachusetts 2017	*Health New England 1-413-787-0010*					
	HNE Medicare Value HMO	**HNE Medicare Basic No Rx HMO**	**HNE Medicare Basic HMO**	**HNE Medicare Plus HMO**	**HNE Medicare Premium No Rx HMO**	**HNE Medicare Premium HMO**
Plan Number	H8578-012	H8578-009	H8578-007	H8578-004	H8578-003	H8578-001
Berkshire	$41	$38	CLOSING FOR 2017	$123	$108	$173
Franklin	$41	$38		$123	$108	$173
Hampden	$41	$38		$123	$108	$173
Hampshire	$41	$38		$123	$108	$173
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**
Health Plan Deductible	None	None		None	None	None
PCP	$35	$30		$20	$15	$15
Specialist	$45	$40		$35	$20	$20
Inpatient Hospital	$225 per day for days 1-7, per admission	$275 per day for days 1-5, per admission		$225 per day for days 1-5, per admission	$100 per day for days 1-5, per admission	$100 per day for days 1-5, per admission
Outpatient Services/Surgery	Ambulatory:$450 Hospital: $450	Ambulatory: $450 Hospital: $450		Ambulatory: $300 Hospital: $300	Ambulatory: $150 Hospital: $150	Ambulatory: $150 Hospital: $150
Outpatient Rehab	$40	$40		$35	$20	$20
Diagnostic Tests and Labs	$25 copay Labs & X-Rays & Therapeutic Radiology $0 up to $250: Diagnostic Radiology (High Cost Imaging)	$0: Labs,mamograms, ultrasounds, $20 X-Rays & Therapeutic Radiology $0 up to $225: Diagnostic Radiology (High Cost Imaging)		$0: Labs,mamograms, ultrasounds/ $15 X-Rays & Therapeutic Radiology $0 up to $225: Diagnostic Radiology (High Cost Imaging)	$0: Labs,mamograms, ultrasounds / $10 X-Rays & Therapeutic Radiology $0 up to $125: Diagnostic Radiology (High Cost Imaging)	$0: Labs,mamograms, ultrasounds / $10 X-Rays & Therapeutic Radiology $0 up to $125: Diagnostic Radiology (High Cost Imaging)
Skilled Nursing/Per benefit Period	Days 1-20: $0 copay per day; Days 21-50: $160 copay per day; Days 51-100: $0 copay per day	Days 1-20: $20 copay per day; Days 21-50: $100 copay per day; Days 51-100 $0 copay per day		Days 1-20: $20 copay per day; Days 21-50: $140 copay per day, Days 51-100 $0 copay per day	Days 1-20: $20 copay per day; Days 21-50 $100 copay per day, Days 51-100 $0 copay per day	Days 1-20: $20 copay per day; Days 21-50 $100 copay per day, Days 51-100 $0 copay per day
Emergency Room	$75 Emergency Room; $50 copay urgent care/walk-in	$75 Emergency Room; $50 copay urgent care/walk-in		$75 Emergency Room; $50 copay urgent care/walk-in	$75 Emergency Room; $50 copay urgent care/walk-in	$75 Emergency Room; $50 copay urgent care/walk-in
Ambulance	$175	$150		$150	$150	$150
DME	20%	20%		20%	15%	15%
Diabetic Supplies	$0	$0		$0	$0	$0
Part B Medications	$0	$0		$0	$0	$0
Annual Maximum	$6,700	$3,400		$3,400	$3,400	$3,400
Drug Deductible	$320 (applies to Preferred Brand, Non-Preferred Brand, Speciality Medication Only)	N/A		$250 (applies to Preferred Brand, Non-Preferred Brand, Speciality Medication Only)	N/A	$250 (applies to Preferred Brand, Non-Preferred Brand, Speciality Medication Only)
Drug Co-pays Tier 1	$4	N/A		$4	N/A	$4
Tier 2	$10	N/A		$10	N/A	$10
Tier 3	$45	N/A		$45	N/A	$45
Tier 4	$95			$95		$95
Tier 5	26%	N/A		28%	N/A	28%
Gap Generic Coverage	No Additional Coverage	N/A		No Additional Coverage	N/A	$4 Preferred Generic - No additional coverage for Generic, Preferred Brand, Non Preferred Brand or Specialty
Vision (Yes/No)	Yes	Yes		Yes	Yes	Yes
Hearing (Yes/no)	Yes	Yes		Yes	Yes	Yes
Dental (Yes/No)	Yes	Yes		Yes	Yes	Yes

Central & Western Massachusetts 2017	*UnitedHealthCare 1-800-547-5514*				
	AARP MedicareComplete Plan 1	**AARP MedicareComplete Plan 2**	**AARP MedicareComplete Plan 3**	**AARP MedicareComplete Choice REGIONAL PPO**	
Plan Number	H1944-005	H1944-006	H-1944-022	R7444-001	
Berkshire				$47	
Franklin				$47	
Hampden	$0	$42	$76	$47	
Hampshire				$47	
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**	**In Network**	**Out of Network**
Health Plan Deductible	$0	$0	$0	$0	$0
PCP	$15	$10	$5	$20	30%
Specialist	$45	$25	$20	$45	$50
Inpatient Hospital	$335 co-pay per day for days 1-5/$0 co-pay for days 6-unlimited	$295 co-pay per day for days 1-6/$0 co-pay for days 7-unlimited	$275 co-pay per day for days 1-5/$0 co-pay for days 6-unlimited	$395 co-pay per day for days 1-4/$0 co-pay for days 5-unlimited	30%
Outpatient Services/Surgery	20% co-insurance	$275 co-pay	$250 co-pay	20% co-insurance	30% co-insurance
Outpatient Rehab	$40	$30	$20	$40	$50
Diagnostic Tests and Labs	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $14 co-pay	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $14 co-pay	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $14 co-pay	20% of the cost	30% of the cost
Skilled Nursing/Per benefit Period	$0 for days 1-20/$160 for days 21-62	$0 for days 1-20/$160 for days 21-45	$0 for days 1-20/$160 for days 21-42	20%	30%
Emergency Room	$75	$75	$75	$75	75%
Ambulance	$250	$225	$225	$250	$250
DME	20%	20%	20%	20%	50%
Diabetic Supplies	$0	$0	$0	$0	30%
Part B Medications	20%	20%	20%	20%	30%
Annual Maximum	$6,700	$3,900	$3,400	$5,500	$10,000
Drug Deductible	None	None	None	None	$0 for Tier 1 and Tier 2; $280 for Tier 3, Tier 4 and Tier 5
Drug Co-pays Tier 1	$3	$2	$2	$2	$2
Tier 2	$9	$8	$8	$12	$12
Tier 3	$45	$45	$45	$47	$47
Tier 4	$95	$95	$95	$100	$100
Tier 5	28%	29%	33%	27%	27%
Gap Generic Coverage					
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes
Hearing (Yes/no)	Yes	Yes	Yes	Yes	Yes
Dental (Yes/No)	No	No	No	No	No