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Metrowest 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 PPO		Medicare PPO Blue ValueRx		Medicare HMO Blue FlexRx (HMO POS)	
Plan Number	H2261-019	H2261-005	H2230-017		H2230-002		H2230-016		H2261-021	
Middlesex	$39	$295	$0		$230		$79		$99	
Norfolk	$39	$295	$0		$230		$79		$99	
Worcester	$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	$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%	$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%
Outpatient Services/Surgery	$250	$150	$300	$300	$150	20%	$225	$225	$200	20%
Outpatient Rehab	$20	$15	$40	$40	$15	20%	$20	$20	$15	20%
Diagnostic Tests and Labs	$30/day Labs and tests, $20/day X-Rays $250/day High Tech Imaging	$10/day Labs, Diag tests, and X-Rays $150/day High Tech Imaging	$30/day Labs , Diag tests, X-Rays $325/day High Tech Imaging $60/visit Radiologic Serv	$30/day Labs, Diag tests and X-Rays $325/day High Tech Imaging $60/visit Radiologic Serv	$10/day Labs, Tests, X-Rays $150/day High Tech Imaging	20% labs, tests and X-Rays, 40% high tech imaging	$20/day labs, tests and X-Rays, $250/day High Tech imaging	$20/day labs, tests and X-Rays, $250/day High Tech imaging	$15/day Labs, Diag tests and X-Rays $200/day High Tech Imaging	20% labs, tests and X-Rays 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%	$20/day (days 1-20) $100/day (days 21-44) $0/day (days 45-100)	20%	$0/day (days 1-20) $160/day (days 21-44) $0/day (days 45-100)	20%	$0/day (days 1-20) $140/day (days 21-44) $0/day (days 45-100)	20%
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%	20%	20%	10%	20%
Diabetic Supplies	$0	$0	$0	$0	$0	20% Co-ins	$0	$0	$0	20%
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	$9,900
Drug Deductible	$320 Tiers 3-5	$200 Tiers 3-5	$400 Tiers 3-5		$200 Tiers 3-5		$320 Tiers 3-5		$260 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	
Dental (Yes/No)	Yes	Yes	Yes		Yes		Yes		Yes	

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Metrowest 2017	*Fallon Community Health Plan 1 - 888 - 377 - 1980*							
	Fallon Senior Plan Super Saver Rx HMO	**Fallon Senior Plan Saver HMO**	**Fallon Senior Plan Saver Enhanced RX HMO**	**Fallon Senior Plan Standard HMO**	**Fallon Senior Plan Standard Enhanced RX HMO**	**FSP Plus Enhanced RX HMO**	**FSP Saver Enhanced RX HMO-POS**	
Plan Number	H9001-032	H9001-029	H9001-030	H9001-001	H9001-015	H9001-031	H9001-013	
Middlesex	$0	$29	$49	N/A	N/A	$156	N/A	
Norfolk	$0	$29	$49	N/A	N/A	$156	N/A	
Worcester	$0	$69	NA	$142	$190	$247	$82	
CO-PAYS - Beneficiary Costs	In Network	In Network	In Network	In Network	In Network	In Network	In Network	Out of Network
Health Plan Deductible	None	None	None	None	None	None	None	
PCP	$20	$25	$25	$15	$15	$10	$25	Not Covered
Specialist	$45	$40	$40	$30	$30	$20	$40	$40
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	$275/day for days 1-5;	$325/day for days 1-5
Outpatient Services/Surgery	$300	$275	$275	$160	$160	$100	$275	$325
Outpatient Rehab	$20	$20	$20	$20	$20	$15	$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 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. $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	$0 per day days 1-20; $150 per day days 21-44;$0 per days 45-100	Not Covered
Emergency Room	$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	$175/$700 OOPM	
DME	20%	20%	20%	15%	15%	10%	20%	Not Covered
Diabetic Supplies	$0	$0	$0	$0	$0	$0	$0	
Part B Medications	20%	20%	20%	15%	15%	10%	20%	
Annual Maximum	6700	$6,700	$6,700	$6,700	$6,700	$3,400	$5,000	
Drug Deductible	$400	N/A	$300 Tiers 3-5	N/A	$200 Tiers 3-5		$300 Tiers 3-5	
Drug Co-pays Tier 1	Pref $2/Non-Pref $7	N/A	Pref $1/Non-Pref $6	N/A	Pref $1/Non-Pref $6	Pref $1/Non-Pref $6	Pref $1/Non-Pref $6	
Tier 2	Pref $7/Non-Pref $12	N/A	Pref $6/Non-Pref $11	N/A	Pref $6/Non-Pref $11	Pref $6/Non-Pref $11	Pref $6/Non-Pref $11	
Tier 3	Pref $42/Non-Pref $47	N/A	Pref $32/Non-Pref $37	N/A	Pref $32/Non-Pref $37	Pref $32/Non-Pref $37	Pref $32/Non-Pref $37	
Tier 4	Pref $95/Non-Pref $100	N/A	Pref $86/Non-Pref $91	N/A	Pref $86/Non-Pref $91	Pref $86/Non-Pref $91	Pref $86/Non-Pref $91	
Tier 5	25%	N/A	27%	N/A	29%	33%	27%	
Gap Generic Coverage	No	N/A	No	N/A	No	No	No	
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Hearing (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Dental (Yes/No)	No	Yes	Yes	Yes	Yes	Yes	Yes	

FALLON Preferred Pharmacies Include: CVS; Target; Wal-Mart; Big Y; Shaws; Stop & Shop; some independent/small chain pharmacies

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Metrowest 2017	***Harvard Pilgrim Health Care 1-877-906-4742***		
	Stride HMO Value RX		**Stride HMO Value Rx Plus**
Plan Number	H1660-009	H1660-012	H1660-001
Middlesex	$57	N/A	$148
Norfolk	$57	N/A	$148
Worcester	N/A	$57	$148
CO-PAYS - Beneficiary Costs	In Network		In Network
Health Plan Deductible	None		None
PCP	$20		$10
Specialist	$40		$30
Inpatient Hospital	$275/Day (Days 1-5) (no limit)		$150/Day (Days 1-5) ($750 annual limit)
Outpatient Services/Surgery	$200		$100
Outpatient Rehab	$20		$15
Diagnostic Tests and Labs	$20 lab, tests and X-Rays , $150 imaging		$0 lab, tests and X-Rays, $60 imaging
Skilled Nursing/Per benefit Period	$20/Day (Days 1-20) $100/Day (Days 21-100)		$0/Day (Days 1-20) $100/Day (Days 21-44)
Emergency Room	$75		$75
Ambulance	$100		$100
DME	20%		20%
Diabetic Supplies	$0		$0
Part B Medications	20%		10%
Annual Maximum	$3,400		$3,400
Drug Deductible	$320 Tiers 3 - 5		None
Drug Co-pays Tier 1	30d $0, 90d mail$0		30d $0, 90d mail$0
Tier 2	30d $10 ,90d mail$20		30d $10, 90d mail $20
Tier 3	30d $47, 90d mail$94		30d $47, 90d mail$94
Tier 4	30d $100, 90d mail/$250		30d $100, 90d mail/$250
Tier 5	26%		33%
Gap Generic Coverage	No		Tier 1 $0/$0
Vision (Yes/No)	Yes		Yes
Hearing (Yes/no)	Yes		Yes
Dental (Yes/No)	Yes		Yes

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Metrowest 2017	*Tufts Health Plan Medicare Preferred HMO 1 - 866 - 974 - 0118*						
	Tufts Medicare Preferred Saver Rx HMO	**Tufts Medicare Preferred Basic Rx HMO**	**Tufts Medicare Preferred Value No RX HMO**	**Tufts Medicare Preferred Value Rx HMO**	**Tufts Medicare Preferred Prime No Rx HMO**	**Tufts Medicare Preferred Prime Rx HMO**	**Tufts Medicare Preferred Prime Rx+ HMO**
Plan Number	H2256-028	H2256-026	H2256-019	H2256-018	H2256-016	H2256-015	H2256-001
Middlesex	$0	$39	$97	$125	$131	$159	$193
Norfolk	$0	$39	$97	$125	$131	$159	$193
Worcester	$0						
CO-PAYS - Beneficiary Costs	In Network	In Network	In Network	In Network	In Network	In Network	In Network
Health Plan Deductible	None	None	None	None	None	None	None
PCP	$20	$10	$10	$10	$10	$10	$10
Specialist	$40	$30	$20	$20	$15	$15	$15
Inpatient Hospital	days 1-5: $350/day	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	$350	$250	$150	$150	$75	$75	$75
Outpatient Rehab	$40	$30	$20	$20	$15	$15	$15
Diagnostic Tests and Labs	$10: Labs,Tests, X-Rays $0: Therapeutic Radiology $300/day: Diagnostic Radiology	$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 $0/day days 21–44 $160/day days 45–100 $0	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	$75
Ambulance	$300	$275	$200	$225	$100	$110	$90
DME	20%	20%	10%	10%	10%	10%	10%
Diabetic Supplies	$0	$0	$0	$0	$0	$0	$0
Part B Medications	$0	$0	$0	$0	$0	$0	$0
Annual Maximum	$3,900	$3,400	$3,400	$3,400	$3,400	$3,400	$3,400
Drug Deductible	$350 Tiers 3- 5	$300 Tiers 3- 5	N/A	$250 Tiers 3- 5	N/A	None	None
Drug Co-pays Tier 1	$6	$4	N/A	$4	N/A	$4	$2
Tier 2	$12	$8	N/A	$8	N/A	$8	$4
Tier 3	$47	$47	N/A	$47	N/A	$47	$30
Tier 4	$100	$100	N/A	$100	N/A	$100	$80
Tier 5	26%	27%	N/A	28%	N/A	33%	33%
Gap Generic Coverage	No	No	N/A	No	N/A	No	Yes, Tiers 1 & 2
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hearing (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dental (Yes/No)	Optional	Optional	Optional	Optional	Optional	Optional	Optional

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Metrowest 2017	*Tufts Health Plan Medicare Preferred HMO 1 - 866 - 974 - 0118*						
	Tufts Medicare Preferred Saver Rx HMO	**Tufts Medicare Preferred Basic No Rx HMO (Worc)**	**Tufts Medicare Preferred Basic Rx HMO (Worc)**	**Tufts Medicare Preferred Value No Rx HMO (Worc)**	**Tufts Medicare Preferred Value Rx HMO (Worc)**	**Tufts Medicare Preferred Prime No Rx HMO (Worc)**	**Tufts Medicare Preferred Prime Rx HMO (Worc)**
Plan Number	H2256-028	H2256-041	H2256-036	H2256-040	H2256-034	H2256-039	H2256-033
Middlesex	$0						
Norfolk	$0						
Worcester	$0	$33	$61	$109	$140	$148	$179
CO-PAYS - Beneficiary Costs	In Network	In Network	In Network	In Network	In Network	In Network	In Network
Health Plan Deductible	None	None	None	None	None	None	None
PCP	$20	$10	$10	$10	$10	$10	$10
Specialist	$40	$30	$30	$20	$20	$15	$15
Inpatient Hospital	days 1-5: $350/day	days 1–5: $275/day	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
Outpatient Services/Surgery	$350	$250	$250	$150	$150	$75	$75
Outpatient Rehab	$40	$30	$30	$20	$20	$15	$15
Diagnostic Tests and Labs	$10: Labs,Tests, X-Rays $0: Therapeutic Radiology $300/day: Diagnostic Radiology	$10: Labs,Tests, X-Rays $0: Therapeutic Radiology $250/day: Diagnostic Radiology	$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
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) $140/day (Days 21–44) $0/day (Days 45-100)	$20/day (Days 1–20) $140/day (Days 21–44) $0/day (Days 45-100)	$20/day (Days 1–20) $100/day (Days 21–44) $0/day (Days 45-100)	$20/day (Days 1–20) $100/day (Days 21–44) $0/day (Days 45-100)	$20/day (Days 1–20) $60/day (Days 21–44) $0/day (Days 45-100)	$20/day (Days 1–20) $60/day (Days 21–44) $0/day (Days 45-100)
Emergency Room	$75	$75	$75	$75	$75	$75	$75
Ambulance	$300	$250	$275	$200	$225	$100	$110
DME	20%	20%	20%	10%	10%	10%	10%
Diabetic Supplies	$0	$0	$0	$0	$0	$0	$0
Part B Medications	$0	$0	$0	$0	$0	$0	$0
Annual Maximum	$3,900	$3,400	$3,400	$3,400	$3,400	$3,400	$3,400
Drug Deductible	$350 Tiers 3 - 5	N/A	$300 Tiers 3 - 5	N/A	$250 Tiers 3 - 5	N/A	None
Drug Co-pays Tier 1	$6	N/A	$4	N/A	$4	N/A	$4
Tier 2	$12	N/A	$6	N/A	$6	N/A	$6
Tier 3	$47	N/A	$47	N/A	$47	N/A	$47
Tier 4	$100	N/A	$85	N/A	$85	N/A	$85
Tier 5	26%	N/A	27%	N/A	28%	N/A	33%
Gap Generic Coverage	No	N/A	No	N/A	No	N/A	No
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hearing (Yes/no)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dental (Yes/No)	Optional	Optional	Optional	Optional	Optional	Optional	Optional

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Metrowest 2017	*UnitedHealthCare* *1 - 800 - 547 - 5514*							
	AARP MedicareComplete Plan 1 HMO		**AARP Medicare Complete Plan 2 HMO**		**AARP Medicare Complete Plan 3 HMO**		**AARP MedicareComplete Choice REGIONAL PPO**	
Plan Number	H1944-001	H1944-005	H-1944-004	H-1944-006	H-1944-021	H-1944-022	R7444-001	
Middlesex	$0	N/A	$42	N/A	$76	N/A	$47	
Norfolk	N/A	N/A	N/A	N/A	N/A	N/A	$47	
Worcester	N/A	$0	N/A	$42	N/A	$76	$47	
CO-PAYS - Beneficiary Costs	In Network		In Network		In Network		In Network	Out of Network
Health Plan Deductible	None		None		None		None	
PCP	$15		$5	$10	$5		$20	30%
Specialist	$40	$45	$30	$25	$20		$45	$50
Inpatient Hospital.	$395/day (days 1-4) $0/day(days 5-unlimited)	$335/day (days 1-5) $0/day(days 6-unlimited)	$295/day (days 1-6) $0/day(days 7-unlimited)		$275/day (days 1-5) $0/day(days 6-unlimited)		$395/day (days 1-4) $0/day(days 5-unlimited)	30%
Outpatient Services/Surgery	20%		$275 co-pay		$250 co-pay		20%	30%
Outpatient Rehab	$40		$30		$20		$40	$50
Diagnostic Tests and Labs	$10 labs, $9 X-Rays 20% tests and imaging		$10 labs, $14 X-Rays 20% tests and imaging		$10 labs, $14 X-Rays 20% tests and imaging		$10 labs, $14 X-Rays 20% tests and imaging	$10 labs 30% X-Rays, tests and imaging
Skilled Nursing/Per benefit Period	$0/day (Days 1-20) $160/day (Days 21-62) $0/day (Days 63-100)		$0/day (Days 1-20) $160/day (Days 21-45) $0/day (Days 46-100)		$0/day (Days 1-20) $160/day (Days 21-42) $0/day (Days 43-100)		$0/day (Days 1-20) $100/day (Days 21-55) $0/day (Days 56-100)	30% up to 100 days
Emergency Room	$75		$75		$75		$75	$75
Ambulance	$225		$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 combined
Drug Deductible	None		None		None		$280 Tiers 3-5	
Drug Co-pays Tier 1	$3	$3	$2	$3	$2		$2	
Tier 2	$11	$9	$8	$11	$8		$12	
Tier 3	$45	$45	$45	$45	$45		$47	
Tier 4	$95	$95	$95	$95	$95		$100	
Tier 5	28%	28%	29%	29%	33%		27%	
Gap Generic Coverage	No		No		No		No	
Vision (Yes/No)	Yes		Yes		Yes		Yes	
Hearing (Yes/no)	Yes		Yes		Yes		Yes	
Dental (Yes/No)	No		No		No		No	