Town of Amherst HMO Health Plan Comparison

	Current Plan (FY18)	MIIA Plan (FY19)
BENEFIT	**HMO**	**MIIA HMO NE BENCHMARK 2 PLAN**
Deductible	None	$300 / $900 (member / family)
Preventive Care Visits	$0	$0
PCP Office Visit	$20	$20 includes PT/OT/ST/Chiropractic
Specialist Office Visit	$30	$45
Emergency Room	$100 (waived if admitted)	$100 after deductible (waived if admitted)
Inpatient Hospital Admission	Covered in full	· General care hospital - $275 after deductible · Higher cost share hospital - $1,500 after deductible
Ambulatory Day/Outpatient Surgical Day	Covered in full	$250 after deductible
Diagnostic X-rays and Lab Tests, excluding MRI's, CT and PET Scans and Nuclear Imaging	Covered in full	Covered in full after deductible
MRI, CT and PET scans and Nuclear Imaging	Covered in full	$100 per category/date of service after deductible
Short-Term Physical and Occupational Therapy	$30 (up to 60 visits per calendar year) Blue Cross	$20 (up to 30 visits per calendar year)
	$20 (up to 60 visits per calendar year) Harvard	
Chiropractic Services	$30 Blue Cross	$20 (up to 20 visits per calendar year)
	$20 (up to 30 visits per calendar year) Harvard	
Hearing Aid Benefit	Up to $2,000 per ear every 3 years	Up to $5,000 per ear every 3 years
Out of Pocket Maximum	$6,600 / $13,200 (member / family)	$2,500 / $5,000 Medical (member / family) $1,000 / $2,000 RX (member / family)
Prescription Drug	Max out of pocket expense inlcuded in overall max	Prescription: $1,000 / $2,000 out of pocket max
Deductible - Retail RX (up to 30-day supply) - Mail Order Drug RX (up to 90-day supply)	N/A $10/30/50 $20/60/100	N/A $10/30/65 $25/75/165

Please see summary of benefits for benefit detail. This exhibit is for illustrative purposes only.

Town of Amherst PPO Health Plan Comparison

	Current Plan (FY18)		MIIA Plan (FY19)	
	PPO		MIIA PPO BENCHMARK 2 PLAN	
BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	None	$100 / $250 (member / family)	$300 / $900 (member / family)	$400 / $800 (member / family)
Preventive Care Visits	$0	20% after deductible	$0	20% after deductible
PCP Office Visit	$20	20% after deductible	$20	20% after deductible
Specialist Office Visit	$30	20% after deductible	$45	20% after deductible
Emergency Room	$100 (waived if admitted)	$100 (waived if admitted)	$100 after deductible (waived if admitted)	$100 after in-network deductible (waived if admitted)
Inpatient Hospital Admission	Covered in full	20% after deductible	· General care hospital - $275 after deductible · Higher cost share hospital - $1,500 after deductible	20% after deductible
Ambulatory Day/Outpatient Surgical Day	Covered in full	20% after deductible	$250 after deductible	20% after deductible
Diagnostic X-rays and Lab Tests, excluding MRI's, CT and PET Scans and Nuclear Imaging	Covered in full	20% after deductible	Covered in full after deductible	20% after deductible
MRI, CT and PET scans and Nuclear Imaging	Covered in full	20% after deductible	$100 per date of service after deductible	20% after deductible
Short-Term Physical and Occupational Therapy	$30 (up to 100 visits per calendar year) Blue Cross	20% after deductible (up to 100 visits per calendar year)	$20 (up to 30 visits per calendar year)	20% after deductible (up to 30 visits per calendar year)
	$20 (up to 100 visits per calendar year) Harvard	20% after deductible (up to 100 visits per calendar year)		
Chiropractic Services	$30 Blue Cross	20% after deductible	$20 (up to 20 visits per calendar year)	20% after deductible (up to 20 vitits per calendar year)
	$20 Harvard	20% after deductible		
Hearing Aid Benefit	Up to $2,000 per ear every 3 years	20% after deductible	Up to $5,000 per ear every 3 years	20% after deductible
Out of Pocket Maximum	$6,600 / $13,200 (member / family)		$2,500 / $5,000 (member / family) $1,000 / $2,000 RX (member / family)	
Prescription Drug				
Deductible	N/A		N/A	
- Retail RX (up to 30-day supply)	$10/30/50	Not Covered	$10/30/65	Not Covered
- Mail Order Drug RX (up to 90-day	$20/60/100	Not Covered	$25/75/165	Not Covered

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