Benefits and Rates
Effective July 1, 2015

Weigh Your Options

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

2015-2016

GIC BENEFIT DECISION GUIDE

FOR COMMONWEALTH OF MASSACHUSETTS

MUNICIPAL

EMPLOYEES, RETIREES AND SURVIVORS

See inside for benefit changes.

ANNUAL ENROLLMENT: April 8 - May 6, 2015

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CHARLES D. BAKER
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LIEUTENANT GOVERNOR

Spring 2015

Dear Colleagues:

Health care has been a major focus of mine for much of my career and I am honored to be working with the Group Insurance Commission again in this new and exciting role as your Governor.

As a former Secretary of Administration and Finance, I took seriously my role on the Commission, attending meetings and working with the GIC staff on how the Commonwealth could best fulfill the need for quality care at reasonable costs, to our employees and to taxpayers. The Commission has been at the forefront of improving healthcare transparency and empowering patients to take charge of their own health and wellbeing. Our administration is a firm believer in doing all we can, to further improve on those goals.

Getting the most out of the complex medical system depends on your active participation as a patient, a consistent relationship with a Primary Care Provider, and coordination of care. Be sure to read through this 2015-2016 Benefit Decision Guide to get an overview of upcoming benefit changes and your options. Take advantage of other GIC resources for selecting your health plan, including the GIC's website, www.mass.gov/gic, and health fairs across the state.

Thank you for your service and for helping us to improve health care quality at costs the taxpayer -- and you -- can afford.

Sincerely,

Charles D. Baker
Governor

HOW TO USE THIS GUIDE

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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NEW THIS YEAR! **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: www.mass.gov/gic/aevideo.**

IMPORTANT REMINDERS

- This ***Benefit Decision Guide*** contains important benefit and rate changes effective July 1, 2015. *Review pages 5-6, and 11 for details.*
- Read the ***Annual Enrollment Checklist*** on page 2 for information to consider when selecting a health plan.
- Read the Employee/Non-Medicare ***Limited Network Plans – Great Value; Quality Coverage*** section on page 21 to find out more about limited network plan options for Employees and Non-Medicare Retirees/ Survivors.
- If you want to ***keep your current GIC health plan***, you do not need to fill out any paperwork. Your coverage will continue automatically.

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

- Your annual enrollment forms or requests are due **no later than Wednesday, May 6, 2015**. All forms are on the GIC's website (www.mass.gov/gic/forms). Changes go into effect July 1, 2015:
  - **Active employees and New GIC Enrollees:** GIC enrollment forms and, if not already enrolled in a GIC plan, required documentation as outlined on the *Forms* section of our website to the GIC Coordinator in your benefits office.
  - **Current Municipal Retirees/Survivors:** For health plan changes, Retiree/Survivor Enrollment/Change form or written request to the GIC. Retiree Dental form to the GIC Coordinator in your benefits office.

ANNUAL ENROLLMENT CHECKLIST

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

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

- If you are retired, determine if you are eligible for Medicare *(see page 12)*.
- Where you live determines which plan(s) you may enroll in. *See the locator map on page 15 for the Employee/Non-Medicare health plans and page 14 for Medicare plans.*
- See the health plan pages for eligibility details *(see pages 22-27)*.

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

- **REVIEW** the at-a-glance charts on pages 16-19 of this guide.
- **WEIGH** features that are important to you, such as out-of-network benefits, prescription drug coverage, and mental health benefits.
- **REVIEW** their monthly rates *(see separate rate chart)*.
- **CONSIDER** enrolling in a limited network plan if you are an employee or Non-Medicare retiree/survivor. Enrollees who pay 25% of the premium ***will save, on average, $50 per month*** *(see page 21)*.
- **CONTACT** the plan to find out about benefits that are not described in this guide.

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

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

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

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

STEP 5: **Retirees and Survivors – take a look at the Retiree Dental Plan** if your municipality participates *(see page 28 for details)*.

THREE GREAT RESOURCES

1. **The plan's website:** Get additional benefit details, information about network physicians, tools to make health care decisions and more. *See page 31 for website addresses.*
2. **The health plan's customer service line:** A representative can help you. *See page 31 for phone numbers.*
3. **A GIC Health Fair:** Talk with plan representatives and get personalized information and answers to your questions. *See page 30 for the health fair schedule.*

NEW HIRE AND ANNUAL ENROLLMENT OVERVIEW

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

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

NEW EMPLOYEES

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

You may enroll in one of these health plans:

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

By submitting within 10 days of employment…

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

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

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

✓ Indicates a GIC Limited Network Plan.

* See page 28 for eligibility details.

EMPLOYEES AND *NON-MEDICARE* RETIREES/SURVIVORS

MEDICARE RETIREES/SURVIVORS

During annual enrollment April 8-May 6, 2015 for changes effective July 1, 2015

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

You may enroll in…

Retiree Dental Plan*

By submitting by May 6…

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

Current Municipal Retirees/ Survivors:
Retiree/Survivor Enrollment/Change form or written request to the GIC asking for the change

Retiree Dental Form to the GIC Coordinator in your benefits office

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

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

You may enroll in…

Retiree Dental Plan*

By submitting by May 6…

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

Current Municipal Retirees/ Survivors:
Retiree/Survivor Enrollment/Change form or written request asking for the change to the GIC

Retiree Dental Form to the GIC Coordinator in your benefits office

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

The Commonwealth continues to face challenging budget times. Many worthy initiatives including education, local aid and transportation are competing for scarce resources as health care costs crowd out the state budget. For this fiscal year, a $765 million shortfall is projected; the GIC has a $165 to $190 million deficit. Most of the GIC budget shortfall is structural – we have been underfunded for the last three years because the budget base was not updated for the additional members that we have added, the end of federal funds, and the supplemental budgets we've received. The Fiscal Year 2016 premium requests we received from the plans, especially two of the larger ones, were not realistic given the budget situation. Additionally, too many patients use expensive academic medical centers for routine care, further increasing costs for all of us.

The Administration has committed to making the GIC's current budget whole. However, despite the new budget base, there's no room for increased spending next year. With many pressing concerns, agencies have been asked to come in with level funding. The GIC has been pushing hard through the Centered Care Initiative to change the way providers are paid: moving from fee for service payment arrangements that reward providers for ordering unnecessary tests and procedures to global payments. This has been a tough slog and progress has been slower than we would like. We will continue to push for these changes, but in the meantime, the Commission has had to make some difficult decisions. These were not easy decisions and they will affect all of us who work for the state and local communities.

We encourage you to take charge of your health and take advantage of ways to lower your out-of-pocket costs.

All members:

- **Work with your Primary Care Provider** (PCP) to navigate the health care system.
- Make copies and **bring the prescription drug formulary** from your plan's website with you to all doctor visits.
- Use **urgent care facilities** and **retail minute clinics** instead of the emergency room for urgent (non-emergency) care.
- Read about ways to **take charge of your health**; the GIC's website has a wealth of articles and links to additional resources: www.mass.gov/gic/yourhealth.
- **Eat healthy, exercise regularly, don't smoke, and find ways to de-stress**.

If you are an Employee or Non-Medicare Retiree/Survivor:

- **Seek care from Tier 1 and Tier 2 specialists.** Over 164 million claims have been analyzed for differences in how physicians perform on nationally recognized measures of quality and/or cost efficiency. You pay the lowest copay for the highest-performing doctors:
  - ★★★ Tier 1 (excellent)
  - ★★ Tier 2 (good)
  - ★ Tier 3 (standard)
- 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 online cost comparison tool** to shop for health care services in advance.
- Consider **enrolling in a Limited Network Plan** to save money on your monthly premium.

Municipal News

The Towns of **Ashland, Easton, Westwood,** and **LABBB Collaborative** will join GIC health benefits effective July 1, 2015.

The Towns of **Ashland, Middleborough,** and **Weston** will be offering the GIC Retiree Dental Plan. During the Spring Open Enrollment, eligible retirees and survivors from these towns and 13 other participating municipalities and school districts may join the plan for coverage effective July 1, 2015. *See page 28 for details.*

BENEFIT CHANGES EFFECTIVE JULY 1, 2015

PCPS AND REFERRALS REQUIRED!

HARVARD PILGRIM INDEPENDENCE PLAN AND TUFTS HEALTH PLAN NAVIGATOR

In keeping with the Centered Care Initiative, Harvard Pilgrim Independence Plan and Tufts Health Plan Navigator will become Point-of-Service (POS) plans. With a POS Plan, members must select a Primary Care Provider (PCP) to manage their care and obtain referrals to specialists to receive care at the in-network level of coverage. Members who get care from specialists without a PCP referral will have higher out-of-pocket costs. Current members of these plans ***will stay in the plan*** if they do not switch plans during Annual Enrollment and will receive additional details of this transition from their plan.

EMPLOYEE/NON-MEDICARE HEALTH PLANS

Rules for Enrolling in Health Plans and Adding Dependents: In compliance with federal and state law for pre-tax benefits, the GIC will be tightening up our rules and instituting deadlines for enrolling in health plans and adding dependents. As always, required documentation (e.g., birth certificates and marriage certificates) must accompany the change forms. *See page 7 for additional information.*

Deductible: The current calendar year deductible will increase to $300 individual; $600 two-person family; and $900 three- or more person family coverage. The carryover provision into 2016 for deductible-related charges incurred October – December 2015 has been eliminated. The deductible will transition to a fiscal year deductible to make it easier for members to change health plan carriers at future annual enrollments. *See page 9 for additional details.*

Other Benefits That Accrue on a Calendar Year: will transition during FY16 to a fiscal year accrual. For 2015, they will accrue on a calendar year; from January 1 – June 30, 2016, they will accrue on a half-calendar year; from July 1, 2016 – June 30, 2017, they will accrue on a fiscal year. Details vary slightly by plan; contact the plan for details:

- Out-of-pocket maximum
- Inpatient copay
- Day limits for other inpatient medical facilities (skilled nursing, rehab, etc.)
- Outpatient surgery copay
- Physical and Occupational Therapy
- Outpatient mental health
- Smoking cessation counseling
- Hearing aids
- Fitness reimbursement
- Nutritional counseling
- Vision hardware for certain conditions
- Vision exam
- Chiropractic visits
- Speech therapy
- Private Duty nursing
- Hospital-based personal emergency response systems

See the At-A-Glance Chart in the center of this guide for the following changes:

Specialist Tiering: Copays for specialists will increase for all plans: $30 Tier 1; $60 Tier 2; $90 Tier 3. Fallon Health Direct Care will tier specialists based on quality and/or cost efficiency for the first time.

Inpatient Hospital Care Copay: For plans that do not tier hospitals (Fallon Health Direct Care, Health New England, Neighborhood Health Plan, UniCare State Indemnity Plan/Basic, and UniCare Community Choice), the copay will increase to $275. Tufts Health Plan Navigator will change to three tier hospital copays and Tier 1 and Tier 3 copays will increase or change for all plans that have three hospital tiers (Fallon Health Select Care, Harvard Pilgrim Independence Plan, Tufts Health Plan Navigator, and UniCare PLUS): Tier 1: $275 and Tier 3: $1,500. For Harvard Pilgrim Primary Choice, Tier 1 will increase to $275.

Outpatient Surgery Copay: The copay will increase to $250 for all plans ***except*** UniCare Community Choice and PLUS.

Prescription Drug Copays: All prescription drug copays except for Tier 1 retail will increase to: Tier 2 $30 and Tier 3 $65 retail up to a 30-day supply; Tier 1 $25; Tier 2 $75 and Tier 3 $165 mail order up to a 90-day supply.

In-Network Out-of-Pocket Maximum: The out-of-pocket maximum ($5,000 per individual and $10,000 per family) will now include prescription drugs for Harvard Independence and Primary Choice, Tufts Navigator and Spirit. (This already applies to the other GIC HMOs.) The out-of-pocket maximum for UniCare State Indemnity Plan/Basic, Community Choice and PLUS will change to $4,000 per individual and $8,000 per family for medical and mental health benefits and $1,500 per individual and $3,000 per family for prescription drug benefits.

Other Employee/Non-Medicare Health Plan Changes

NEIGHBORHOOD HEALTH PLAN

- NHP Care will now be called NHP Prime.
- Prosthetics and orthotics with Durable Medical Equipment (DME) will be subject to the deductible, but not coinsurance.
- Hearing aid benefits for members over age 22 will no longer be subject to coinsurance.

TUFTS HEALTH PLAN NAVIGATOR AND SPIRIT

- **Mental Health/Substance Abuse:** Outpatient mental health visits up to 26 visits without prior authorization; thereafter, visits subject to prior authorization for medical necessity.

UNICARE STATE INDEMNITY PLAN/BASIC, COMMUNITY CHOICE AND PLUS

- **Prescription Drug Program:** CVS/caremark was selected to continue as the pharmacy benefit manager. Prior authorization will be required for certain high-cost drugs. *See page 20 for additional information.*
- **Certain Oral, Injectable, Infused and Inhaled Specialty Drugs:** After the first fill of certain specialty drugs, you must get refills through CVS/caremark's specialty pharmacy. The first fill may be limited to up to a 14-day supply with a prorated copay.
- **Mental Health/Substance Abuse:** One visit with a PCP for mental health/substance abuse will now be covered. Outpatient mental health visits up to 26 visits without prior authorization; thereafter, visits subject to prior authorization for medical necessity.

Medicare Health Plan Changes

Rules for Enrolling in Health Plans and Adding Dependents: In compliance with federal and state law for pre-tax benefits, the GIC will be tightening up our rules and instituting deadlines for enrolling in health plans and adding dependents. As always, required documentation (e.g., birth certificates and marriage certificates) must accompany the change forms. *See page 7 for additional information.*

Prescription Drug Copays: All prescription drug copays except for Tier 1 retail will increase to: Tier 2 $30 and Tier 3 $65 retail up to a 30-day supply; Tier 1 $25; Tier 2 $75 and Tier 3 $165 mail order up to a 90-day supply. For Fallon Senior Plan and Tufts Medicare Preferred, these changes will go into effect January 1, 2016.

UNICARE STATE INDEMNITY PLAN/MEDICARE EXTENSION

- **Prescription Drug Program:** CVS/caremark was selected to continue as the pharmacy benefit manager. Prior authorization will be required for certain high-cost drugs. *See page 20 for additional information.*

  Certain Oral, Injectable, Infused and Inhaled Specialty Drugs: After the first fill of certain specialty drugs, you must get refills through CVS/caremark's specialty pharmacy. The first fill may be limited to up to a 14-day supply with a prorated copay.
- **Prescription Drug Program Will Become an Employer Group Waiver Plan (EGWP) Effective January 1, 2016:** The prescription drug benefit will transition to an EGWP Program, a Medicare Part D plan, with additional coverage provided by the GIC. Members of UniCare State Indemnity/ Medicare Extension and their Medicare-eligible spouse and dependents will automatically be enrolled.

  Under this program:
  - Low-income retirees may be eligible for subsidies and reduced copayments;
  - The Medicare Part D premium is included in your monthly health insurance rate. However, enrollees deemed by Social Security to have high income will also pay an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Part D. Visit Social Security's or Medicare's website for more information;
  - Benefits of the plan will match or be similar to the UniCare Non-Medicare health plan drug program;
  - Because of the additional coverage provided by the GIC, your coverage will be better than a standard Medicare prescription drug plan; and
  - You will have more retail pharmacy options for filling your 90-day maintenance medications.

We will send you additional details about the EGWP Program in the late summer; for Annual Enrollment, you do not need to do anything if you want to stay in this health plan.

Other GIC Benefit Changes

RETIREE DENTAL: Composite fillings on posterior teeth will now be covered.

Modifications to Rules for Enrolling in Health Plans and Adding Dependents

In compliance with federal and state law for pre-tax benefits, the GIC will be tightening up our rules and instituting deadlines for enrolling in health plans and adding dependents effective July 1, 2015. As always, required documentation (e.g., birth certificates and marriage certificates) must accompany the change forms.

Effective July 1, 2015:

- All GIC forms have changed. Visit our website for current forms: www.mass.gov/gic/forms.
- GIC eligible enrollees can only enroll in coverage for the first time as a new hire, at Annual Enrollment or during the year with 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.
- GIC members can only change from individual to family or family to individual coverage with 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.
- All forms and documentation for the above enrollments or changes ***must*** be received at the GIC within 60 days of the qualifying event. If you miss this deadline, you must wait for the next Annual Enrollment to make the change.

As always, it's important to remember that you 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.

Frequently Asked Questions

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

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

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

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

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

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

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

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

You should not sign up for an individual Medicare Part D on your own; prescription drug benefits are provided by your GIC health or drug plan.

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

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

FREQUENTLY ASKED QUESTIONS

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

A If you or your covered spouse is age 65 or over and eligible for Medicare Part A for free, but the other one is under age 65, the person under age 65 will continue to be covered under a Non-Medicare plan until he/she becomes eligible for Medicare coverage. The person age 65 or over must enroll in a GIC Medicare Plan. If you have Medicare/Non-Medicare combination coverage, you must enroll in one of the pairs of plans listed on page 12.

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, the family must change plans. Only UniCare Indemnity Plan/Basic is nationwide.

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

You MUST Notify Your Benefits Office (active employees) or the GIC (retirees and survivors) 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. When any of the following occur, active employees must notify the GIC Coordinator in their benefits office and retirees and survivors must write to the GIC:

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

DEDUCTIBLE CHANGES AND QUESTIONS & ANSWERS

Information on this page does not apply to the GIC Medicare Plans.

The calendar year deductible for **Employee and Non-Medicare retiree/survivor** health plans will increase effective July 1, 2015. The deductible will transition to a fiscal year to make it easier for members to change health plan carriers at Annual Enrollment. The carryover provision of October – December has been eliminated.

Deductible Questions and Answers

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

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

Q ***How much is the in-network 2015 calendar year deductible?***

A The deductible will increase effective July 1, 2015 to $300 up to a maximum of $900 per family.

Here is how it works for each coverage level:

- **Individual:** The individual has a $300 deductible before benefits begin.
- **Two-person family:** Each person must satisfy a $300 deductible.
- **Three- or more person family:** The maximum each person must satisfy is $300 until the family as a whole reaches the new $900 maximum.

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

Q ***I've already satisfied my calendar year deductible; will I need to pay more toward my deductible in 2015?***

A Yes. If you already paid $250 for your individual calendar year deductible, you will be subject to another $50 for the rest of the 2015 calendar year. Two-person families and families of three or more people that have met their deductible may incur an additional $100 or $150, respectively.

The calendar year deductible will transition to a fiscal year deductible next year to make it easier to change health plan carriers at Annual Enrollment. Here's how this will work:

For Calendar Year 2015:

The deductible will remain on a calendar year.

For January – June 2016, there will be a half-year deductible:

- **Individual:** The individual will have a $150 deductible before benefits begin.
- **Two-person family:** Each person must satisfy a $150 deductible.
- **Three- or more person family:** The maximum each person must satisfy is $150 until the family as a whole reaches the six-month $450 maximum.

Effective July 1, 2016: the deductible year will run July 1, 2016 – June 30, 2017.

Q ***If I change health plans during this 2015-2016 Annual Enrollment, am I subject to another deductible?***

A ***You will not be subject to a new deductible if:***

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

You will be subject to a new deductible this annual enrollment only if:

You choose a different GIC health plan carrier.

DEDUCTIBLE CHANGES AND QUESTIONS & ANSWERS

Q ***Will the deductible-related charges that I incur in October – December 2015 be applied toward my half-year calendar year deductible that begins January 1, 2016?***

A No. The carryover provision has been eliminated.

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

A The lists below 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 below may occur depending upon individual patient circumstances and a plan's schedule of benefits***.

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

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

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

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

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

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

When you visit a doctor or hospital, the provider 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.

Information on this page does not apply to the GIC Medicare Plans.

MONTHLY GIC FULL COST RATES

Effective July 1, 2015

Full Cost Rates Including the 0.4% Administrative Fee

For the rate you will pay as a municipal employee or retiree/survivor, see separate rate chart from your municipality or the GIC's website: www.mass.gov/gic/munirates.

Employee & Non-Medicare Retiree/Survivor Health Plans

HEALTH PLAN	PLAN TYPE	INDIVIDUAL	FAMILY
Fallon Health Direct Care	HMO	$492.89	$1,182.96
Fallon Health Select Care	HMO	654.98	1,571.91
Harvard Pilgrim Independence Plan	POS	749.39	1,828.49
Harvard Pilgrim Primary Choice Plan	HMO	599.51	1,462.80
Health New England	HMO	494.17	1,225.14
NHP Prime (Neighborhood Health Plan)	HMO	470.71	1,247.36
Tufts Health Plan Navigator	POS	659.25	1,609.60
Tufts Health Plan Spirit	HMO-type	501.40	1,207.85
UniCare State Indemnity Plan/Basic *with CIC* (Comprehensive)	Indemnity	974.65	2,281.72
UniCare State Indemnity Plan/Basic *without CIC* (Non-comprehensive)	Indemnity	932.32	2,183.55
UniCare State Indemnity Plan/Community Choice	PPO-type	472.29	1,136.29
UniCare State Indemnity Plan/PLUS	PPO-type	655.64	1,566.91

Medicare Plans

HEALTH PLAN	PLAN TYPE	PER PERSON
Fallon Senior Plan*	Medicare (HMO)	$302.13
Harvard Pilgrim Medicare Enhance	Medicare (Indemnity)	392.24
Health New England MedPlus	Medicare (HMO)	360.95
Tufts Health Plan Medicare Complement	Medicare (HMO)	353.91
Tufts Health Plan Medicare Preferred*	Medicare (HMO)	275.60
UniCare State Indemnity Plan/Medicare Extension (OME) *with CIC* (Comprehensive)	Medicare (Indemnity)	403.98
UniCare State Indemnity Plan/Medicare Extension (OME) *without CIC* (Non-comprehensive)	Medicare (Indemnity)	393.47

* Benefits and rates of Fallon Senior Plan and Tufts Health Plan Medicare Preferred are subject to federal approval and may change January 1, 2016.

Medicare Guidelines

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

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

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

When you (the insured) retire:

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

Retiree and Spouse Coverage if Under and Over Age 65

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

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

Health Plan Combination Choices

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

How to Calculate Your Rate

See separate rate chart from your municipality.

Retiree and Spouse Both on Medicare

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

Retiree and Spouse Coverage if Under and Over Age 65

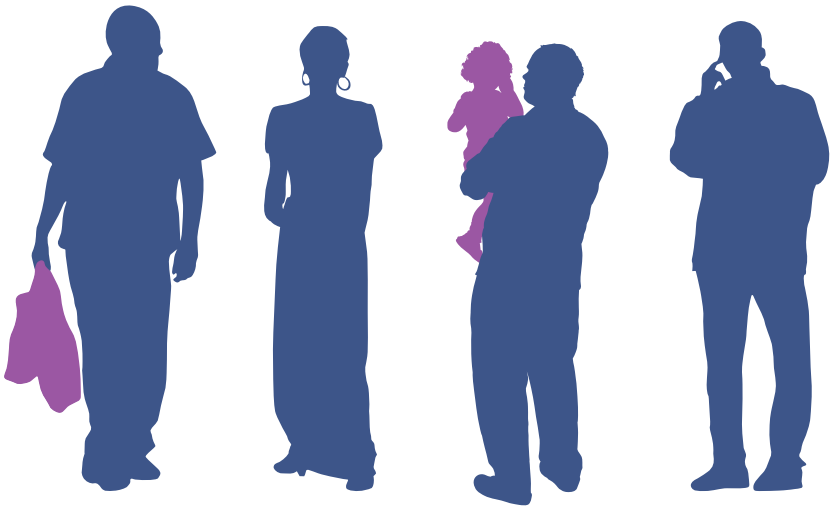
1. Find the premium for the Medicare Plan in which the Medicare retiree or spouse will be enrolling.
2. Find the individual coverage premium for the Non-Medicare Plan in which the Non-Medicare retiree or spouse will be enrolling.
3. Add the two premiums together; this is the total that you will pay monthly.

Helpful Reminders

- Visit Social Security's website or your local Social Security office for more information about Medicare benefits.
- HMO Medicare plans require you to live in their service area. *See the Medicare Health Plan Locator Map on page 14.*
- You may change GIC Medicare plans ***only during annual enrollment***, unless you have a qualifying event, such as moving out of your plan's service area. Note: Even if your doctor or hospital drops out of your Medicare HMO, you must stay in the HMO until the next annual enrollment. Your Medicare HMO will help you find another provider.
- Benefits and rates of Fallon Senior Plan and Tufts Health Plan Medicare Preferred are subject to federal approval and may change January 1, 2016; you cannot change plans until the spring Annual Enrollment period. These plans, and the UniCare State Indemnity/Medicare Extension (OME) Plan effective January 1, 2016, automatically include Medicare Part D prescription drug benefits.

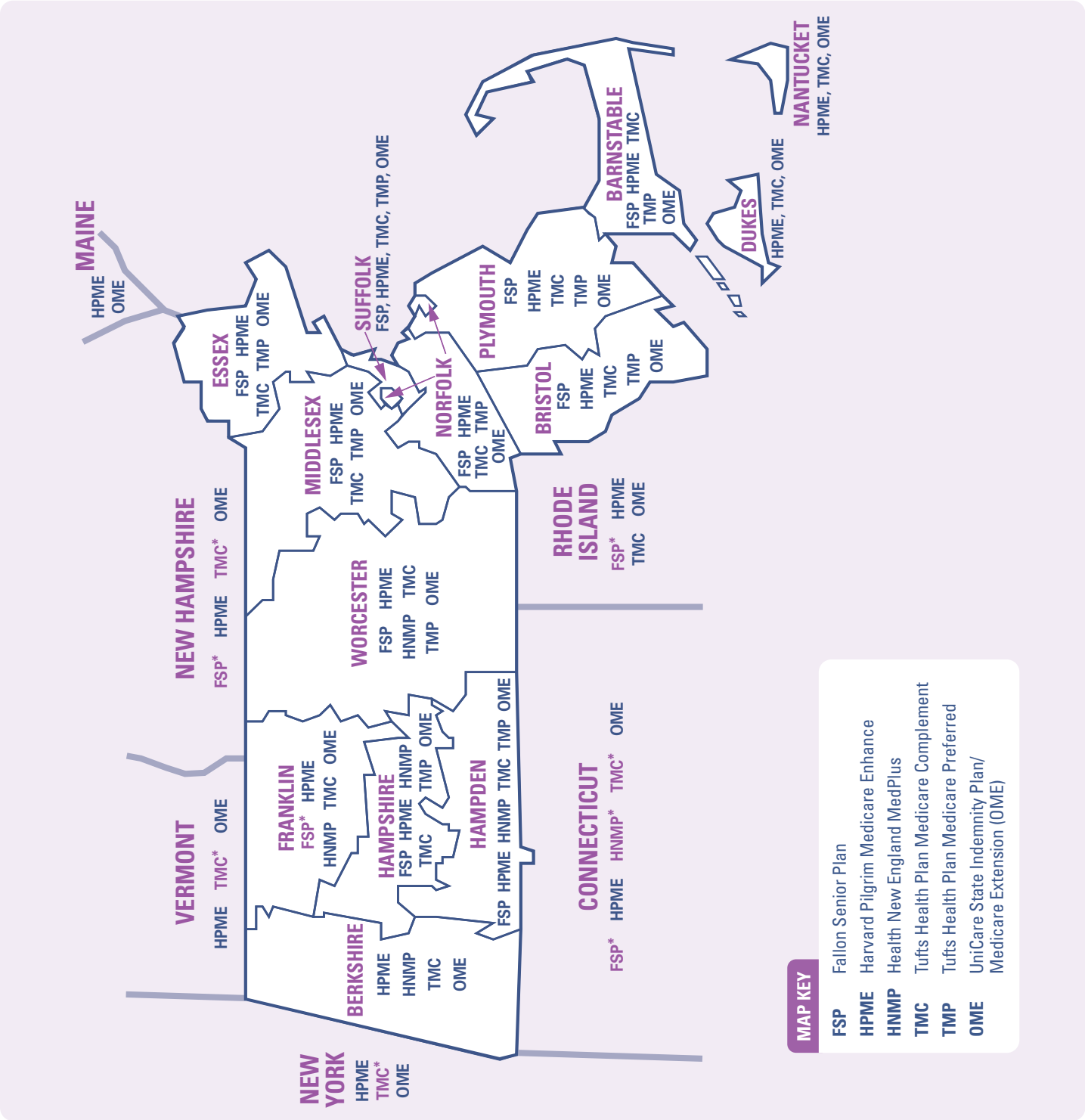
Medicare Part D and Your Prescription Drug Benefits

Most enrollees should not enroll in an individual federal Medicare drug plan. *See page 20 for additional details.*



MEDICARE HEALTH PLAN LOCATOR MAP

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



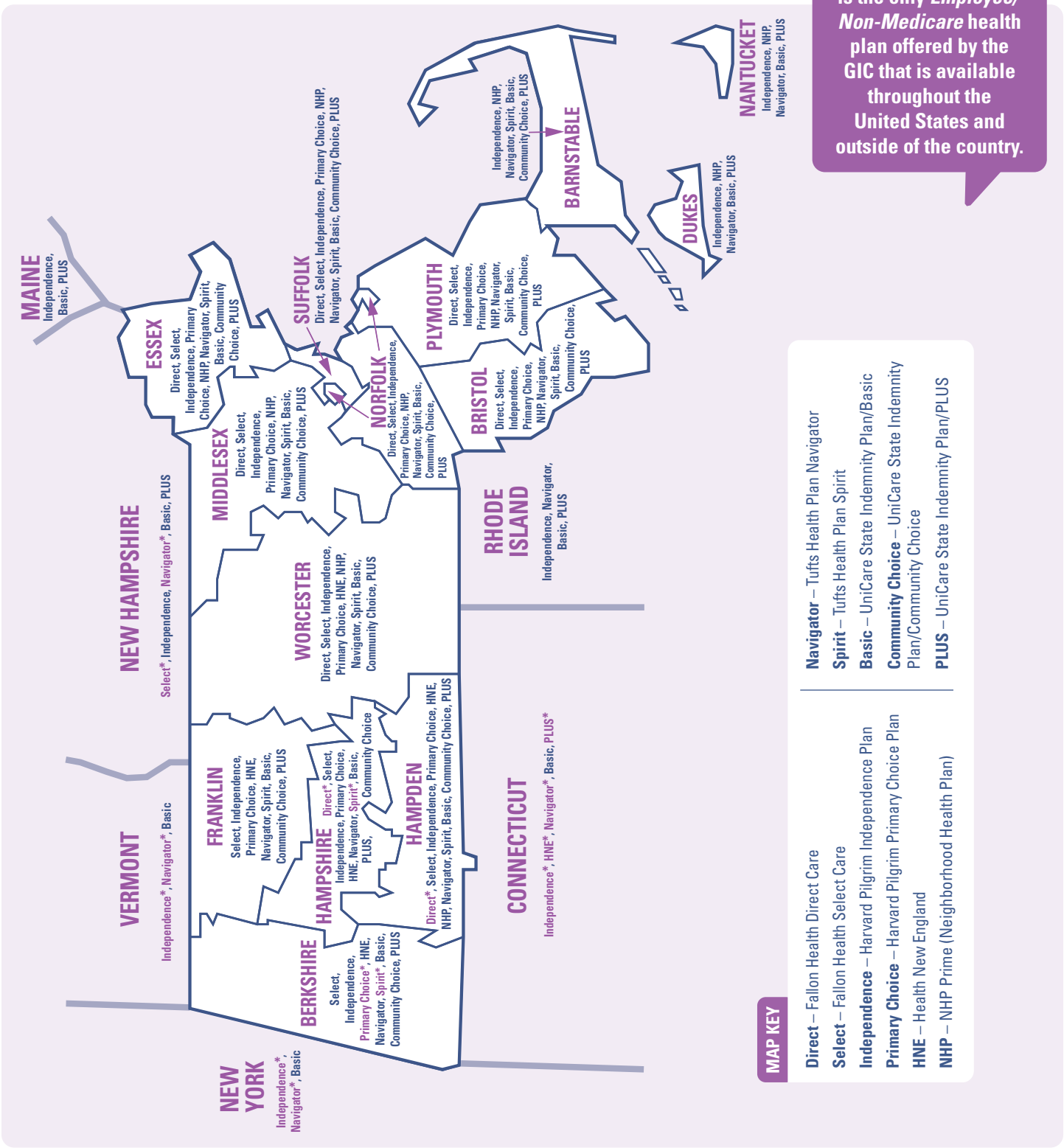
The Harvard Pilgrim Medicare Enhance Plan is available throughout the United States. The UniCare State Indemnity Plan/Medicare Extension is available throughout the United States and outside of the country.

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

EMPLOYEE/NON-MEDICARE HEALTH PLAN LOCATOR MAP

Where You Live Determines Which Plan You May Enroll In. Is the EMPLOYEE/Non-Medicare Health Plan Available Where You Live?

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



MAP KEY

Direct – Fallon Health Direct Care
Select – Fallon Health Select Care
Independence – Harvard Pilgrim Independence Plan
Primary Choice – Harvard Pilgrim Primary Choice Plan
HNE – Health New England
NHP – NHP Prime (Neighborhood Health Plan)

Navigator – Tufts Health Plan Navigator
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

* 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.

BENEFITS AT-A-GLANCE: Employee/ Non-Medicare Health Plan Copays & Deductibles

This chart is a comparative overview of GIC plan benefits. See the Plan Navigator, and UniCare State Indemnity Plan/Community Cho With the exception of emergency care, there are no out-of-networ

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
Calendar Year Deductible					
Individual	**$300**	**$300**	**$300**	**$300**	**$300**
Two-person family	**$600**	**$600**	**$600**	**$600**	**$600**
Three- or more person family	**$900**	**$900**	**$900**	**$900**	**$900**
Primary Care Provider Office Visit	$15 per visit	$20 per visit	$20 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 (excellent)	**$30 per visit**	**$30 per visit**	**$30 per visit**	**$30 per visit**	**$30 per visit**
★★ Tier 2 (good)	**$60 per visit**	**$60 per visit**	**$60 per visit**	**$60 per visit**	**$60 per visit**
★ Tier 3 (standard)	**$90 per visit**	**$90 per visit**	**$90 per visit**	**$90 per visit**	**$90 per visit**
Retail Clinic	$15 per visit	$20 per visit	$20 per visit	$20 per visit	$20 per visit
Outpatient Mental Health & Substance Abuse Care	$15 per visit	$20 per visit	$20 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 calenda	
Tier 1	**$275 per admission** with no tiering	**$275 per admission**	**$275 per admission**	**$275 per admission**	**$275 per admission** with no tiering
Tier 2		$500 per admission	$500 per admission	$500 per admission	
Tier 3		**$1,500 per admission**	**$1,500 per admission**	No Tier 3	
Outpatient Surgery				Maximum four copays per calendar	
	$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)					Maximur
	$100 per scan	$100 per scan	$100 per scan	$100 per scan	$100 per scan
Prescription Drug					
Retail: up to a 30-day supply					
Tier 1	$10	$10	$10	$10	$10
Tier 2	**$30**	**$30**	**$30**	**$30**	**$30**
Tier 3	**$65**	**$65**	**$65**	**$65**	**$65**
Mail-order: Maintenance drugs – up to a 90-day supply					
Tier 1	**$25**	**$25**	**$25**	**$25**	**$25**
Tier 2	**$75**	**$75**	**$75**	**$75**	**$75**
Tier 3	**$165**	**$165**	**$165**	**$165**	**$165**

The amounts and terms that appear in bold in this chart are benefits that have changed effective July 1, 2015.

Out-of-pocket maximums apply to medical and mental health benefits across all health plans. Prescription dr maximums in all health plans except UniCare, which has one out-of-pocket maximum for medical & mental h

e corresponding overview information for each plan for more information. Benefits described below for the Harvard Pilgrim Independence Plan, Tufts Health oice and PLUS are ***in-network*** benefits with PCP referral where required. These plans also offer out-of-network benefits with higher out-of-pocket costs. rk benefits for the GIC's EPO and HMOs. For providers, benefit details, exclusions, and limitations, see the plan handbook or contact the individual 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 $10,000	$5,000 $10,000	$5,000 $10,000	**$4,000 medical & mental health/$1,500 Rx** **$8,000 medical & mental health/$3,000 Rx**	**$4,000 medical & mental health/$1,500 Rx** **$8,000 medical & mental health/$3,000 Rx**	**$4,000 medical & mental health/$1,500 Rx** **$8,000 medical & mental health/$3,000 Rx**
$300 **$600** **$900**	**$300** **$600** **$900**	**$300** **$600** **$900**	**$300** **$600** **$900**	**$300** **$600** **$900**	**$300** **$600** **$900**
$20 per visit	$20 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	$20 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)*
r 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**
r quarter or 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
m one 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
$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**

ug (Rx) benefits are included in the out-of-pocket
ealth and a separate maximum for prescription drugs.

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

BENEFITS AT-A-GLANCE: Medicare Health Plan Copays & Deductibles

This chart is an overview of the plan benefits. It is not a complete description. Benefits are subject to certain definitions, conditions, limitations and exclusions as spelled out in the respective plan documents. With the exception of emergency care, there are no out-of-network benefits for the GIC's Medicare HMOs.

HEALTH PLAN	FALLON SENIOR PLAN	HARVARD PILGRIM MEDICARE ENHANCE	HEALTH NEW ENGLAND MEDPLUS
PLAN TYPE	HMO	INDEMNITY	HMO
PCP Designation Required	Yes	No	Yes
PCP Referral to Specialist Required	Yes	No	No
Calendar Year Deductible	None	None	None
Preventive Care Office visits according to health plan's schedule	No copay	No copay	No copay
Physician Office Visit (except mental health)	$10 per visit	$10 per visit	$10 per visit
Retail Clinic	$10 per visit	$10 per visit	$10 per visit
Outpatient Mental Health and Substance Abuse Care	$10 per visit	$10 per visit	$10 per visit
Inpatient Hospital Care	No copay	No copay	No copay
Hospice Care	No copay	No copay	No copay
Diagnostic Laboratory Tests and X-rays	No copay	No copay	No copay
Surgery Inpatient & Outpatient	No copay	No copay	No copay
Emergency Room Care (includes out-of-area)	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)
Hearing Aids	First $500 covered at 100%; 80% coverage for the next $1,500 per person, per two-year period		
Prescription Drug **Retail:** up to 30-day supply			
Tier 1	$10	$10	$10
Tier 2	**$30**	**$30**	**$30**
Tier 3	**$65**	**$65**	**$65**
Mail order: Maintenance drugs up to a 90-day supply			
Tier 1	**$25**	**$25**	**$25**
Tier 2	**$75**	**$75**	**$75**
Tier 3	**$165**	**$165**	**$165**

The amounts and terms that appear in bold in this chart are benefits that have changed effective July 1, 2015.

Benefits and rates of Fallon Senior Plan and Tufts Health Plan Medicare Preferred are subject to federal approval and may change effective January 1, 2016. Prescription drug copays for these plans will increase to the copays listed effective January 1, 2016.

For more information about a specific plan's benefits or providers, call the plan or visit its website.

TUFTS HEALTH PLAN MEDICARE COMPLEMENT	TUFTS HEALTH PLAN MEDICARE PREFERRED	UNICARE STATE INDEMNITY PLAN MEDICARE EXTENSION (OME) ***with CIC*** *(Comprehensive)* Without CIC, deductibles are higher and coverage is only 80% for some services. Contact the plan for details.
HMO	HMO	INDEMNITY
Yes	Yes	No
Yes	Yes	No
None	None	$35 per person
No copay	No copay	No copay
$10 per visit	$10 per visit	No copay
$10 per visit	$10 per visit	No copay
$10 per visit	$10 per visit	First 4 visits: no copay; visits 5 and over: $10 per visit
No copay	No copay	$50 per admission (maximum one copay per person per calendar year quarter)
No copay	No copay	No copay
No copay	No copay	No copay
No copay	No copay	No copay in MA and for out-of-state providers who accept Medicare; call the plan for details if using out-of-state providers who do not accept Medicare
$50 per visit (waived if admitted)	$50 per visit (waived if admitted)	$25 per visit (waived if admitted)
First $500 covered at 100%; 80% coverage for the next $1,500 per person, per two-year period		
$10 **$30** **$65**	$10 **$30** **$65**	$10 **$30** **$65**
$25 **$75** **$165**	**$25** **$75** **$165**	**$25** **$75** **$165**

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

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.

Tip for Reducing Your Prescription Drug Costs

Use Mail Order: Are you taking prescription drugs for a long-term condition, such as asthma, high blood pressure, allergies, or high cholesterol? Switch your prescription from a retail pharmacy to mail order. It can save you money — $5-$30 for three months of medication, depending on the tier. ***See the at-a-glance charts on pages 16-19 for copay details.*** Once you begin mail order, you can conveniently order refills by phone or online. Contact your plan for details.

Prescription Drug Programs

Some GIC plans have the following programs to encourage the use of safe, effective and less costly prescription drugs. Contact the plans you are considering to find out details about these programs:

- **Mandatory Generics –** When filling a prescription for a brand name drug for which there is a generic equivalent, you will be responsible for the cost difference between the brand name drug and the generic, *plus* the generic copay.
- **Step Therapy –** This program requires enrollees to try effective, less costly drugs before more expensive alternatives will be covered.
- **Maintenance Drug Pharmacy Selection –** If you receive 30-day supplies of your maintenance drugs at a retail pharmacy, you must call your prescription drug plan to tell them whether or not you wish to change to 90-day supplies through either mail order or certain retail pharmacies.
- **Specialty Drug Pharmacies –** If you are prescribed 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 to your doctor's office.

Medicare Part D Prescription Drug Reminders and Warnings

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

- A "Notice of Creditable Coverage" is in your plan handbook. It provides proof that you have comparable or better coverage than Medicare Part D. If you should later enroll in an individual Medicare drug plan because of changed circumstances, you ***must*** show the Notice of Creditable Coverage to the Social Security Administration to avoid paying a penalty. Keep this notice with your important papers.
- If you are a member of Harvard Medicare Enhance, Health New England MedPlus or Tufts Medicare Complement and have extremely limited income and assets, contact the Social Security Administration to find out about subsidized Part D coverage. If you are eligible, you may want to enroll in one of the GIC's Medicare Part D Plans (Fallon Senior Plan, Tufts Medicare Preferred, and, in January, UniCare State Indemnity Plan/Medicare Extension).
- If you are a member of one of our Medicare Advantage plans (Fallon Senior Plan and Tufts Health Plan Medicare Preferred), or the UniCare State Indemnity Plan/Medicare Extension (OME) effective January 1, 2016, your plan automatically includes or will include Medicare Part D coverage. If you enroll in another Medicare Part D drug plan, the Centers for Medicare & Medicaid Services will automatically dis-enroll you from your GIC Medicare Advantage health plan, which means you will **no longer have a Medicare plan through the GIC**.

UniCare Prescription Drug Formulary and Prior Authorization Change Effective July 1, 2015

To control escalating prescription drug costs, the GIC is moving to a new formulary for all UniCare members. Certain high-cost drugs with lower-cost alternatives will only be covered based on medical necessity. Prior authorization will be required. For additional details, contact CVS/caremark.

EMPLOYEE/NON-MEDICARE LIMITED NETWORK PLANS –
Great Value; Quality Coverage

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

Limited network plans help address differences in provider costs. You will enjoy ***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 percentage 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 a limited network plan instead of a wide network plan, you will ***save, on average, $50 per month and $600 per year.***

See the separate municipal rate chart from your municipality or on our website to calculate your savings.

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

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

For participating physician and other provider details, contact the individual plans by phone or visit their website *(see page 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 28 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 55 hospitals. The plan is available throughout Massachusetts, except for Cape Cod, Martha's Vineyard, Nantucket, and parts of Berkshire County.
- **Health New England –** a western and central Massachusetts-based HMO that includes 20 Massachusetts hospitals.
- **NHP Prime (Neighborhood Health Plan) –** an HMO with a provider network that includes community health centers, independent medical groups and hospital group practices, as well as 56 hospitals. NHP Prime is available across most of the state except for Berkshire, Franklin, and Hampshire Counties.
- **Tufts Health Plan Spirit –** an EPO (HMO-type) plan with a network of 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 55 hospitals. All Massachusetts physicians participate. The plan is available throughout Massachusetts, except for Martha's Vineyard and Nantucket.

Your Responsibility Before You Enroll in a Plan

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

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

Effective July 1, 2015, Fallon Health Direct Care will tier the following specialists based on quality and/or cost efficiency: Allergists/Immunologists, Cardiologists, Endocrinologists, Gastroenterologists, Hematologists/ Oncologists, Nephrologists, Neurologists, Obstetricians/Gynecologists, Orthopedists, Otolaryngologists (ENTs), Podiatrists, Pulmonologists, Rheumatologists, and Urologists. Members will pay lower copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see how your provider 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

Harvard Pilgrim Health Care tiers the following Massachusetts specialists based on quality and/or cost efficiency: Allergists/ Immunologists, Cardiologists, Dermatologists, Endocrinologists, Gastroenterologists, General Surgeons, Neurologists, Obstetricians/Gynecologists, Ophthalmologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, and Rheumatologists. Members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see if your provider is in the network and how he/she is rated.

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

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 the following specialists based on quality and/or cost efficiency: Cardiologists, Endocrinologists, Gastroenterologists, General Surgeons, Obstetricians/ Gynecologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, and Rheumatologists. Members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see how your provider is rated.

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, formerly known as NHP Care, 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 the following specialists based on quality and/or cost efficiency: Cardiologists, Endocrinologists, Gastroenterologists, Obstetricians/Gynecologists, Otolaryngologists (ENTs), Orthopedists, Pulmonologists, and Rheumatologists. Members pay lower office visit copays when they see Tier 1 and Tier 2 specialists. Contact the plan to see how your provider is rated.

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 mental 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

Tufts Health Plan tiers the following Massachusetts specialists based on quality and/or cost efficiency: Cardiologists, Dermatologists, Endocrinologists, Gastroenterologists, General Surgeons, Neurologists, Obstetricians/Gynecologists, Ophthalmologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, Rheumatologists, and Urologists. Members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see if your provider is in the network and how he/she is rated.

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

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 mental 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.

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.

Specialist and Hospital Tiering

Fallon Health tiers the following specialists based on quality and/or cost efficiency: Allergists/Immunologists, Cardiologists, Endocrinologists, Gastroenterologists, Hematologists/Oncologists, Nephrologists, Neurologists, Obstetricians/Gynecologists, Orthopedists, Otolaryngologists (ENTs), Podiatrists, Pulmonologists, Rheumatologists, and Urologists. Members pay lower copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see how your provider 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

Effective July 1, 2015, the Harvard Pilgrim Independence Plan, administered by Harvard Pilgrim Health Care, will become 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.

Specialist and Hospital Tiering

Harvard Pilgrim Health Care tiers the following Massachusetts specialists based on quality and/or cost efficiency: Allergists/Immunologists, Cardiologists, Dermatologists, Endocrinologists, Gastroenterologists, General Surgeons, Neurologists, Obstetricians/Gynecologists, Ophthalmologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, and Rheumatologists. Members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see if your provider is in the network and how he/she is rated.

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

Eligibility

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

Harvard Independence and Tufts Navigator will become POS Plans Effective July 1, 2015.

New PCP & Referral Requirements

- Has the ***same wide network*** of doctors, hospitals and other providers and includes out-of-network benefits as the current PPO offering does.
- ***Requires a PCP designation and referrals*** from your PCP for specialty care.
- If you ***do not get a referral*** to a specialist, you will have health care benefits, but with ***higher out-of-pocket costs.***

Tufts Health Plan Navigator POS

Effective July 1, 2015, Navigator by Tufts Health Plan will become 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 mental 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.

Specialist and Hospital Tiering

Tufts Health Plan tiers the following Massachusetts specialists based on quality and/or cost efficiency: Cardiologists, Dermatologists, Endocrinologists, Gastroenterologists, General Surgeons, Neurologists, Obstetricians/Gynecologists, Ophthalmologists, Orthopedists, Otolaryngologists (ENTs), Pulmonologists, Rheumatologists, and Urologists. Members pay lower office visit copays when they see Tier 1 or Tier 2 specialists. Contact the plan to see if your provider is in the network and how he/she is rated.

The plan also tiers hospitals based on quality and/or cost. Effective July 1, 2015, the plan will change from two to three hospital tiers. 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.

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 these additional provider charges, if you use non-Massachusetts doctors or hospitals, contact the plan to find out which doctors and hospitals in your area participate in UniCare's national network of providers.

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

Fallon Senior Plan HMO

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

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

Fallon Senior Plan is a Medicare plan under contract with the federal government that includes Medicare Part D prescription drug benefits. Contact the plan for details. ***This Medicare plan's benefits and rates are subject to federal approval and may change January 1, 2016.***

Eligibility

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B who live in the service area are eligible.

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

Harvard Pilgrim Medicare Enhance Indemnity

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

Eligibility

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B who live in the United States are eligible.

Health New England MedPlus HMO

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

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

Eligibility

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B who live in the service area are eligible.

Tufts Health Plan Medicare Complement HMO

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

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

Eligibility

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B who live in the service area are eligible.

Tufts Health Plan Medicare Preferred HMO

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

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

Tufts Health Plan Medicare Preferred HMO is a Medicare Advantage plan under contract with the federal government that includes Medicare Part D prescription drug benefits. Contact the plan for details. ***This Medicare plan's benefits and rates are subject to federal approval and may change January 1, 2016.***

Eligibility

Retirees, Survivors, and their eligible dependents with Medicare Part A and Part B who live in the service area are eligible.

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

UniCare State Indemnity Plan/Medicare Extension (OME) Indemnity

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

Effective January 1, 2016, members will be automatically enrolled in Medicare Part D as the drug benefit of this plan transitions to an Employer Group Waiver Plan (EGWP). *See page 6.*

Eligibility

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

GIC RETIREE DENTAL PLAN

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

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

Benefit Enhancement Effective July 1, 2015:

- Composite fillings on posterior teeth

As a member of this plan, you may go to the dentist of your choice. However, you will save money by visiting one of the over 293,000 nationwide network of participating dentists. When you visit a MetLife provider, your out-of-pocket expenses will be lower as you usually pay the lower negotiated fee, even after you have exceeded your annual maximum.

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

Eligibility

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

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

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

Enrollment

Eligible retirees and survivors may join during annual enrollment, or if you experience a qualifying status change, such as when COBRA dental coverage ends, when you become a survivor of a GIC member, or at retirement. ***However, if you drop coverage in the future, you can never re-enroll in the plan.***

GIC RETIREE DENTAL PLAN

Includes 0.4% Administrative Fee

Monthly GIC Plan Rates as of July 1, 2015

$1,250 Maximum Annual Benefit per Member

COVERAGE TYPE	RETIREE PAYS MONTHLY
SINGLE	$29.06
FAMILY	$69.98

Retiree Dental Questions?

Contact MetLife: 1.866.292.9990

www.metlife.com/gic

NEED MORE HELP?

Attend a Health Fair

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

- Speak with health and other benefit plan representatives;
- Pick up detailed materials and provider directories;
- Ask GIC staff about your benefit options;
- Enroll in a health plan – remember to bring Required Documents with you *(for the list, see the Municipal Forms section of our website)*;
- Enroll in Retiree Dental if your municipality participates *(see page 28)*; and
- Take advantage of complimentary health screenings.

See page 30 for the schedule.

Inscripción Anual

La inscripción anual es del 8 de abril al 6 de mayo, y los cambios entrarán en vigor el 1 de julio de 2015. 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 2015 年 4 月 8 日至 5 月 6 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 8 tháng 4 đến ngày 6 tháng 5 và những thay đổi sẽ có hiệu lực kể từ ngày 1 tháng 7 năm 2015. 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

www.mass.gov/gic

See our website for:

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

FOR MORE INFORMATION, ATTEND A GIC HEALTH FAIR

APRIL 2015

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

11 SATURDAY 11:00-2:00
North Shore Community College
Math and Science Building, 1st Floor Lobby
1 Ferncroft Road
DANVERS

13 MONDAY 11:00-4:00
Oliver Ames High School
Nixon Gym
100 Lothrop Street
EASTON

14 TUESDAY 11:00-4:00
Ashland Community Center
162 West Union Street
Route 135
ASHLAND

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

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

17 FRIDAY 11:00-4:00
Middlesex Community College
Cafeteria
591 Springs Road
BEDFORD

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

22 WEDNESDAY 11:00-3:00
U-Mass Amherst
Student Union Ballroom
AMHERST

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

28 TUESDAY 10:00-3:00
McCormack State Office Building
One Ashburton Place
21st Floor
BOSTON

29 WEDNESDAY 11:00-4:00
Westwood High School Gym
200 Nahatan Street
WESTWOOD

30 THURSDAY 11:00-3:00
Quinsigamond Community College
Harrington Learning Center
Rooms 109 A & B
670 West Boylston Street
WORCESTER

Commonwealth of Massachusetts
Group Insurance Commission

FOR MORE INFORMATION, CONTACT THE PLANS

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

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

OTHER QUESTIONS?

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

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

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

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

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

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

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

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

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

EGWP (Employer Group Waiver Plan) – an employer-provided Medicare Part D prescription drug plan. Effective January 1, 2016, members of the UniCare State Indemnity/Medicare Extension (OME) Plan will be automatically enrolled in an EGWP. Due to the additional coverage provided by the GIC, under EGWP, you have similar coverage to Non-Medicare plan retirees, better coverage than offered by a standard Medicare prescription drug plan, and low-income retirees may be eligible for subsidies and reduced copayments.

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

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

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

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

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).

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

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

Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747
Boston, MA 02114

COMMONWEALTH OF MASSACHUSETTS

Website:
www.mass.gov/gic

Charlie Baker, *Governor*
Karyn Polito, *Lieutenant Governor*

Group Insurance Commission
Dolores L. Mitchell, *Executive Director*
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