

BENEFIT COMPARISON		TOWN OF CANTON			
BENEFIT	HMO BLUE	MEDEX 3 - OBRA (INCLUDES MEDICARE BENEFITS)	BLUE CARE ELECT PREFERRED IN-NETWORK	BLUE CARE ELECT PREFERRED OUT-OF-NETWORK	
Deductible	\$15 co-pay where applicable	\$50 per calendar year only for retail pharmacy prescription drugs	None	\$250 per member \$500 per family	
Coinsurance Maximum	None	None	None	\$1,000 per member \$2,000 per family	
Lifetime Benefit Maximum	None	None	None	None	
INPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	
General Hospital (semi-private room and board and special services)	Nothing	Nothing to 365 days per benefit period benefit maximum	Nothing	20% coinsurance* Nothing (no deductible) for emergency/accident admissions	
Physician Services	Nothing	Nothing to 365 days per benefit period benefit maximum	Nothing	20% coinsurance* Nothing (no deductible) for emergency/accident admissions	
Skilled Nursing Facility	Nothing for up to 100 days per calendar year	Nothing to 100 days per benefit period; then \$16 per day days 101 - 365 benefit maximum	Nothing to 100 days per calendar year benefit maximum combined with out-of-network days	20% coinsurance* to 100 days per calendar year benefit maximum combined with in-network days	
Rehabilitation Hospital	Nothing for up to 60 days per calendar year	Nothing to 100 days per benefit period; then \$16 per day days 101 - 365 benefit maximum	Nothing to 60 days per calendar year benefit maximum combined with out-of-network days	20% coinsurance* to 60 days per calendar year benefit maximum combined with in-network days	

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OUTPATIENT HOSPITAL	YOU PAY	YOU PAY			
Emergency Room Visits for Emergency or Accident Care	\$50, Waived if admitted	Nothing	\$50 per visit	\$50 per visit	
Emergency Room Visits for Medical Care	\$50, Waived if admitted	Nothing	\$50 per visit	20% coinsurance*	
Surgery	Nothing	Nothing	Nothing	20% coinsurance*	
Radiation and Chemotherapy	Nothing	Nothing	Nothing	20% coinsurance*	
Diagnostic X-ray and Lab	Nothing	Nothing	Nothing	20% coinsurance*	
Dialysis	Nothing	Nothing	Nothing	20% coinsurance*	
Physical Therapy	\$15 co-pay, up to 60 visits per calendar year	Nothing	\$15 per visit to 100 visits per calendar year benefit maximum combined with out-of-network visits	20% coinsurance* to 100 visits per calendar year benefit maximum combined with in-network visits	
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	
Surgery	Nothing	Nothing	\$15 per visit	20% coinsurance*	

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Medical Care	Covered in full after \$15 co-pay	Nothing	\$15 per visit	20% coinsurance*
Well Child Care	Covered in full after \$15 co-pay	N/A	\$15 per visit: 10 visits 1st year 3 visits 2nd year 1 visit/yr (age 2-11) 1 visit/ 2 yrs (age 12-18)	20% coinsurance* 10 visits 1st year 3 visits 2nd year 1 visit/year (age 2-11) 1 visit/2 yrs (age 12-18)
Routine GYN Exam	Covered in full after \$15 co-pay	Nothing (1 visit every 3 years)	\$15 per visit 1 visit per calendar year in and out-of-network combined	20% coinsurance*
Routine Vision Exam	Covered in full after \$15 co-pay (one every 24 month period)	All charges	\$15 per visit (1 visit per calendar year)	All charges
Adult Routine Physicals	Covered in full after \$15 co-pay	All charges	\$15 per visit 1 visit/5 years age 19-29 1 visit/3 years age 30-39 1 visit/2 years age 40-54 1 visit/year age 55+	20% coinsurance*: 1 visit/5 years age 19-29 1 visit/3 years age 30-39 1 visit/2 years age 40-54 1 visit/year age 55+
MENTAL HEALTH	YOU PAY	YOU PAY	YOU PAY	YOU PAY
BIOLOGICALLY-BASED CONDITIONS+				
- Inpatient admissions in a general or mental hospital	Nothing	Nothing to 365 days per benefit period benefit maximum	Nothing	20% coinsurance*
- Outpatient visits	Covered in full after \$15 co-pay	Nothing	\$15 per visit	20% coinsurance*
NON-BIOLOGICALLY-BASED MENTAL CONDITIONS (Includes drug addiction and alcoholism)				

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- Inpatient admissions in a general hospital	Nothing	Nothing to 365 days per benefit period benefit maximum	Nothing	20% coinsurance*
- Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing	Nothing to 120 days per benefit period benefit maximum (at least 60 days per calendar year)	Nothing	20% coinsurance*
- Outpatient visits (up to 24 visits per calendar year)	Covered in full after \$15 co-pay	Nothing then, for Medicare-covered services, nothing from 25th visit	\$15 per visit	20% coinsurance*
ALCOHOLISM TREATMENT (IN ADDITION TO NON-BIOLOGICALLY BASED MENTAL CONDITIONS)				
- Inpatient admissions in a general hospital	Nothing	Nothing	Nothing	20% coinsurance*
- Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing	Nothing	Nothing	20% coinsurance*
- Outpatient visits++ (up to 8 visits per calendar year)	\$15 co-pay per visit	Nothing then, for Medicare-covered services, nothing from 9th visit	\$15 per visit	20% coinsurance*
OTHER OUTPATIENT				
	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse Home Health Care	Nothing	Nothing	Nothing	20% coinsurance
Durable Medical Equipment	All charges beyond the \$1500 calendar year benefit maximum	Nothing	Nothing to \$1,500 per calendar year benefit maximum combined with out-of-network maximum	20% coinsurance* to \$1,500 per calendar year benefit max combined with in-network max
Ambulance	Nothing	Nothing	Nothing	Nothing for accident or emergency 20% coinsurance* other medically
Routine Pediatric	Nothing	N/A	All charges	All charges

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