

Town of Marion Health Plan Proposed Offerings effective July 1, 2025

BENEFIT	HMO Blue NE \$250 Deductible w/ HCCS (Benchmark 1)	HMO Blue NE \$500 Deductible w/ HCCS (Benchmark 3)	Blue Care Elect- \$500 Deductible w/HCCS - PPO		Select Saver \$2,000 Deductible w/Copays
Network	New England	New England	National		Limited Network in MA Only
			In-Network	Out-of-Network	
Deductible	\$250 / \$750 (member / family)	\$500/ \$1,000 (member / family)	\$500 / \$1,000 (member / family)		\$2,000/ \$4,000 (Individual / family)*
Out of Pocket Maximum	Medical Services: \$2,000 individual / \$4,000 family Prescription Services: \$2,000 individual / \$4,000 family	Medical Services: \$2,000 individual / \$4,000 family Prescription Services: \$2,000 individual / \$4,000 family	Medical Services: \$2,000 individual / \$4,000 family Prescription Services: \$2,000 individual / \$4,000 family		Medical Services combined with Rx: \$6,450 individual / \$12,900 family
Preventive Care Visits	\$0	\$0	\$0	20% coinsurance after deductible	\$0
PCP Office Visit	\$20	\$20	\$20	20% coinsurance after deductible	\$20 after deductible
Specialist Office Visit	\$35	\$60	\$60	20% coinsurance after deductible	\$35 after deductible
Emergency Room	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)		\$150 after deductible (waived if admitted)
Inpatient Hospital Admission	· General care hospital - \$300, after deductible · Higher cost share hospital - \$700, after deductible	· General care hospital - \$500, after deductible · Higher cost share hospital - \$1,000 after deductible	· General care hospital - \$500, after deductible · Higher cost share hospital - \$1,000, after deductible	20% coinsurance after deductible	\$500 after deductible
Ambulatory Day/Outpatient Surgical Day	\$150 after deductible	\$250 after deductible	\$250 after deductible	20% coinsurance after deductible	\$250 after deductible
Diagnostic X-rays and Lab Tests	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Covered in full after deductible
MRI, CT and PET scans and Nuclear Imaging	\$100 per date of service after deductible	\$100 per date of service after deductible	\$100 per date of service after deductible	20% coinsurance after deductible	\$125 per date of service after deductible
Short-Term Physical and Occupational Therapy	\$20 (up to 60 visits pcy)	\$20 (up to 60 pcy)	\$20 (up to 60 visits pcy)	20% coinsurance after deductible	\$35 copay after deductible (up to 30 pcy)
Routine Vision Exam	Covered in full (one visit every 24 months)	Covered in full (one visit every 24 months)	Covered in full (one visit every 24 months)	20% coinsurance after deductible	Covered in full (one visit every 24 months)
Prescription Drug		Rx Deductible: \$100/\$200	Rx Deductible: \$100/\$200		Deductible then:
- Retail RX (up to 30-day supply)	\$10/25/50	\$10/30/65	\$10/30/65	not covered	\$10/30/65
- Mail Order Drug RX (up to 90-day supply)	\$20/50/110	\$20/75/165	\$20/75/165	not covered	\$20/75/165
Monthly Employee 40% Contribution Rates:					
Individual	\$488.34	\$463.44	\$662.06		\$337.51
Family	\$1,313.79	\$1,253.10	\$1,613.15		\$912.59
Bi-Weekly Employee Contribution Rates:					
Individual	\$244.17	\$231.72	\$331.03		\$168.76
Family	\$656.90	\$626.55	\$806.58		\$456.30

* Bi-Weekly Employee Contributions assume 24 payperiods not 26.

** For the Saver Plan if enrolled in family coverage the full family deductible amount of \$4,000 before services are paid after the deductible.