Office of the
TREASURER

TELEPHONE: (508) 841-8359
FAX: (508) 841-8316
wricciardi@shrewsburyma.gov

TOWN OF SHREWSBURY

Richard D. Carney Municipal Office Building
100 Maple Avenue
Shrewsbury, Massachusetts 01545-5338

ATTN: Permanent-Benefit Eligible Employees working over 20 hours per week
Retirees under age 65 or not Medicare Eligible

ACTIVE PLAN OPEN ENROLLMENT BENEFITS FAIR
Friday, April 26, 2019
1:00 PM – 5:00 PM
SELECTMEN'S MEETING ROOM, TOWN HALL

Health Insurance Program (HIP) for FY 2020

The FY 20 Open Enrollment period will take place beginning **Wednesday, April 17th through Wednesday, May 1st**. The attached Plan Comparison chart is a high level overview of all the plans offered by WSHG, and is also available on the Town's website, www.shrewsburyma.gov/332/Employee-Benefits. Each of the plan's rates can be found on the attached Approved Rate Sheet. Please review this information to help you to determine which plan is right for you and your family.

The following will take place for Fiscal Year 2020:

- If you are currently enrolled in a health plan and not making any changes during this Open Enrollment- **you do not need to do anything**.
- Town and employee contribution ratios are not changing.
- The limited dental benefit offered under the Fallon plan remains in place.
- The Town will continue to offer (HSA) Health Savings Account-qualified High Deductible Health Plans (HDHP).

If you are enrolling in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA) through Health Equity will be established. In order to contribute to an (HSA), an individual or family must be covered by an HSA-qualified HDHP.

By selecting an HSA-qualified plan, you are eligible to contribute tax-free money through payroll deductions into a Health Savings Account. If you are a Non-Medicare Retiree and you choose to enroll in a HDHP, your HSA contributions must be directly paid to Health Equity, the Town's HSA Administrator. Your HSA funds can then be used tax-free to pay for qualified medical expenses. In addition, your HSA contributions earn tax-fee interest and carry over from year-to-year.

All Federal rules will be followed for the establishment of Health Savings Accounts. The Town will contribute annually $1000 for individual plans and $2000 for family plans into the HSA for fiscal years 2020 and 2021. For FY 2020 and 2021 the Town will make the HSA contribution in two equal installments on or about July 1st and January 1st each year. For more information on Health Savings Accounts, please contact Health Equity at 1-866-346-5800 or visit their website at www.healthequity.com .

If you have detailed questions about any of the plans, additional information can be found at www.westsuburbanhealth.com . Member Services phone numbers and website addresses for the Health Insurance Companies and the HSA Administrator are listed below.

Insurance Company	Customer Service	Website
Blue Cross/Blue Shield	(800) 782-3675	www.bcbsma.com
Harvard Pilgrim Health Care	(888) 333-4742	www.harvardpilgrim.org
Fallon	(800) 868-5200	www.fchp.org
Tufts	(800) 843-1008	www.tuftshealthplan.com
Health Equity (HSA)	(866) 346-5800	www.healthequity.com

Open Enrollment Benefits Fair

Please make an effort to attend the Open Enrollment Benefits Fair on **April 26th**. You will have the opportunity to review your options with representatives from our Health Insurance carriers as well as Health Equity (HSA), Cafeteria Plan Advisors (FSA) and Altus Dental.

Representatives from two programs offered through the West Suburban Health Group, Diabetes Care Rewards and TeleMedicine will also be in attendance.

There will also be free Wellness Screenings available for you: Stress Management Screening and Derma-View Facial Analyzer Screening.

Changes to Your Health Insurance

1. To make a change from your existing coverage to another plan, enroll or cancel coverage for yourself or any of your dependents, or to enroll with the Town as a new subscriber this year, please complete the insurance application provided with the Insurance Company's brochure at the Open Enrollment Fair or found on the Town's website. If you are enrolling in a HDHP, you must complete an HSA deduction form (even if you are contributing 0 amount), this is also located on the Town's website.

2. If adding dependents for the first time, you will need to include a copy of their Social Security Card(s), your city / town issued marriage certificate or divorce decree to include a spouse/ex-spouse, and copies of birth certificates, adoption forms, guardianship papers etc., to enroll children under age 26.

3. If the change you are making results in a change to the premium, you will pay for the coverage (new, increase or decrease) and you are required to complete a new Payroll Agreement form, also available on the Town's website.

Please Note: decisions made during Open Enrollment are binding for the entire fiscal year and cannot be changed until next year's Open Enrollment unless you experience a qualifying event that allows for benefit changes during the year. If this happens, you MUST notify Wendy Ricciardi, Benefits Administrator, of such a change within 30 days of the qualifying event date.

If you are not making any changes, you do not need to do anything.

All applications and accompanying paperwork must be returned to Wendy Ricciardi, Benefits Administrator, in the Treasurer's Office by 4:30 on Wednesday, May 1, 2019.

School Employees: Please DO NOT send your forms through the interoffice mail.

Sincerely,

Wendy Ricciardi

Benefits Administrator

TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2019-2020

JUNE PAYROLL CHANGES FOR JULY 1, 2019 OPEN-ENROLLMENT

% PAID TOWN/EMP	PLAN TYPE	TOTAL MONTHLY	TOWN MONTHLY	TOWN 26 P/R BI-WEEKLY*	TOWN 21 P/R BI-WEEKLY**	EMPLOYEE MONTHLY	EMP. 26 P/R BI-WEEKLY	EMP. 21 P/R BI-WEEKLY*	COBRA
INDEMNITY PLANS									
Harvard Pilgrim PPO									
50/50	**FAMILY**	***$5,800.00***	$2,900.00	$1,338.46	$1,657.14	**$2,900.00**	**$1,338.46**	**$1,657.14**	$5,916.00
50/50	FAMILY (SS)	***$5,800.00***	$2,900.00	$1,338.46	$1,657.14	$2,900.00	$1,338.46	$1,657.14	
50/50	**INDIVIDUAL**	***$2,612.00***	$1,306.00	$602.77	$746.29	**$1,306.00**	**$602.77**	**$746.29**	$2,664.24
50/50	INDIVIDUAL (SS)	***$2,612.00***	$1,306.00	$602.77	$746.29	$1,306.00	$602.77	$746.29	
HIGH DEDUCTIBLE HEALTH PLANS WITH HEALTH SAVINGS ACCOUNTS (HSA)									
BLUE CROSS HSA QUALIFED PLAN									
60/40	**FAMILY**	***$2,231.00***	$1,338.60	$617.82	$764.91	**$892.40**	**$411.88**	**$509.94**	$2,275.62
50/50	FAMILY (SS)	***$2,231.00***	$1,115.50	$514.85	$637.43	$1,115.50	$514.85	$637.43	
60/40	**INDIVIDUAL**	***$831.00***	$498.60	$230.12	$284.91	**$332.40**	**$153.42**	**$189.94**	$847.62
50/50	INDIVIDUAL (SS)	***$831.00***	$415.50	$191.77	$237.43	$415.50	$191.77	$237.43	
TUFTS HSA QUALIFED PLAN									
60/40	**FAMILY**	***$2,098.00***	$1,258.80	$580.98	$719.31	**$839.20**	**$387.32**	**$479.54**	$2,139.96
50/50	FAMILY (SS)	***$2,098.00***	$1,049.00	$484.15	$599.43	$1,049.00	$484.15	$599.43	
60/40	**INDIVIDUAL**	***$801.00***	$480.60	$221.82	$274.63	**$320.40**	**$147.88**	**$183.09**	$817.02
50/50	INDIVIDUAL (SS)	***$801.00***	$400.50	$184.85	$228.86	$400.50	$184.85	$228.86	
HPHC HSA QUALIFED PLAN									
60/40	**FAMILY**	***$1,957.00***	$1,174.20	$541.94	$670.97	**$782.80**	**$361.29**	**$447.31**	$1,996.14
50/50	FAMILY (SS)	***$1,957.00***	$978.50	$451.62	$559.14	$978.50	$451.62	$559.14	
60/40	**INDIVIDUAL**	***$750.00***	$450.00	$207.69	$257.14	**$300.00**	**$138.46**	**$171.43**	$765.00
50/50	INDIVIDUAL (SS)	***$750.00***	$375.00	$173.08	$214.29	$375.00	$173.08	$214.29	
FALLON SELECT HSA QUALIFED PLAN									
73/27	**FAMILY**	***$1,713.00***	$1,250.49	$577.15	$714.57	**$462.51**	**$213.47**	**$264.29**	$1,747.26
50/50	FAMILY (SS)	***$1,713.00***	$856.50	$395.31	$489.43	$856.50	$395.31	$489.43	
73/27	**INDIVIDUAL**	***$635.00***	$463.55	$213.95	$264.89	**$171.45**	**$79.13**	**$97.97**	$647.70
50/50	INDIVIDUAL (SS)	***$635.00***	$317.50	$146.54	$181.43	$317.50	$146.54	$181.43	
FALLON DIRECT HSA QUALIFED PLAN									
78/22	**FAMILY**	***$1,595.00***	$1,244.10	$574.20	$710.91	**$350.90**	**$161.95**	**$200.51**	$1,626.90
50/50	FAMILY (SS)	***$1,595.00***	$797.50	$368.08	$455.71	$797.50	$368.08	$455.71	
78/22	**INDIVIDUAL**	***$592.00***	$461.76	$213.12	$263.86	**$130.24**	**$60.11**	**$74.42**	$603.84
50/50	INDIVIDUAL (SS)	***$592.00***	$296.00	$136.62	$169.14	$296.00	$136.62	$169.14	
(SS) REPRESENTS SURVIVING SPOUSE									
****SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)***									
BENCHMARK HMO PLANS									
BLUE CROSS NETWORK BLUE BENCHMARK									
60/40	**FAMILY**	***$2,759.00***	$1,655.40	$764.03	$945.94	**$1,103.60**	**$509.35**	**$630.63**	$2,814.18
50/50	FAMILY (SS)	***$2,759.00***	$1,379.50	$636.69	$788.29	$1,379.50	$636.69	$788.29	
60/40	**INDIVIDUAL**	***$1,029.00***	$617.40	$284.95	$352.80	**$411.60**	**$189.97**	**$235.20**	
50/50	INDIVIDUAL (SS)	***$1,029.00***	$514.50	$237.46	$294.00	$514.50	$237.46	$294.00	$1,049.58
TUFTS BENCHMARK									
60/40	**FAMILY**	***$2,709.00***	$1,625.40	$750.18	$928.80	**$1,083.60**	**$500.12**	**$619.20**	$2,763.18
50/50	FAMILY (SS)	***$2,709.00***	$1,354.50	$625.15	$774.00	$1,354.50	$625.15	$774.00	
60/40	**INDIVIDUAL**	***$1,035.00***	$621.00	$286.62	$354.86	**$414.00**	**$191.08**	**$236.57**	$1,055.70
50/50	INDIVIDUAL (SS)	***$1,035.00***	$517.50	$238.85	$295.71	$517.50	$238.85	$295.71	
HPHC BENCHMARK									
60/40	**FAMILY**	***$2,524.00***	$1,514.40	$698.95	$865.37	**$1,009.60**	**$465.97**	**$576.91**	$2,574.48
50/50	FAMILY (SS)	***$2,524.00***	$1,262.00	$582.46	$721.14	$1,262.00	$582.46	$721.14	
60/40	**INDIVIDUAL**	***$969.00***	$581.40	$268.34	$332.23	**$387.60**	**$178.89**	**$221.49**	$988.38
50/50	INDIVIDUAL (SS)	***$969.00***	$484.50	$223.62	$276.86	$484.50	$223.62	$276.86	
FALLON SELECT BENCHMARK									
73/27	**FAMILY**	***$2,032.00***	$1,483.36	$684.63	$847.63	**$548.64**	**$253.22**	**$313.51**	$2,072.64
50/50	FAMILY (SS)	***$2,032.00***	$1,016.00	$468.92	$580.57	$1,016.00	$468.92	$580.57	
73/27	**INDIVIDUAL**	***$754.00***	$550.42	$254.04	$314.53	**$203.58**	**$93.96**	**$116.33**	$769.08
50/50	INDIVIDUAL (SS)	***$754.00***	$377.00	$174.00	$215.43	$377.00	$174.00	$215.43	
FALLON DIRECT BENCHMARK									
78/22	**FAMILY**	***$1,890.00***	$1,474.20	$680.40	$842.40	**$415.80**	**$191.91**	**$237.60**	$1,927.80
50/50	FAMILY (SS)	***$1,890.00***	$945.00	$436.15	$540.00	$945.00	$436.15	$540.00	
78/22	**INDIVIDUAL**	***$702.00***	$547.56	$252.72	$312.89	**$154.44**	**$71.28**	**$88.25**	$716.04
50/50	INDIVIDUAL (SS)	***$702.00***	$351.00	$162.00	$200.57	$351.00	$162.00	$200.57	
(SS) REPRESENTS SURVIVING SPOUSE									
****SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)***									

WEST SUBURBAN HEALTH GROUP

IMPORTANT - PLEASE READ

The attached benefit comparison chart is a high level overview of the plans offered by WSHG.

The plan documents available to registered users on the carrier websites are the documents that describe full and complete plan details.

The carrier documents are the only documents that coverage is based on.

Should you have a question about specific coverage, you will need to contact the Member Service number on your ID card for detail or visit the carrier website.

WEST SUBURBAN HEALTH GROUP

Effective 07-01-2019

HEALTH PLAN COMPARISON CHART - all plans - July 1, 2019

red font indicates change or clarification	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN		FALLON HEALTH	
PLAN TYPE	PPO		BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK	CHOICENET	HSA ELIGIBLE	NETWORK BLUE NE	HSA ELIGIBLE		HSA ELIGIBLE		HSA ELIGIBLE
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None	None	None	None	None	None	None
Deductible - (Benchmark Plans only) applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - *See plan document for full details*			IND $300 FAM $900	IND $2,000 FAM $4,000 (Non-embedded, plan year deductible, family plan deductible needs to be satisfied before insurance plan kicks in)	IND $300 FAM $900	IND $2,000 FAM $4,000	IND $300 FAM $900	IND $2,000 FAM $4,000	IND $300 FAM $900	IND $2,000 FAM $4,000
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year. Effective July 1, 2015, out-of-pocket maximums for prescription copays have been added as required by ACA (in-network only).			**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year see plan for details	**Medical & RX COMBINED** - $5,000 per member $10,000 per family per plan year year see plan for details	**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year see plan for details	**Medical & RX COMBINED** - $5,000 per member $10,000 per family per plan year see plan for details	**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year, see plan for details	**Medical & RX COMBINED** - $5,000 per member $10,000 per family per plan year, see plan for details	**Medical & Prescription Combined** - $2,000 Individual $4,000 Family per plan year	**Medical & RX COMBINED** - $5,000 per member $10,000 per family per plan year see plan for details
Family Covered	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Any PCP in network	No selection required	Member must select	Member must select	Member must select	Member must select	No selection required	Member must select	Member must select	Member must select
Specialist Referrals	Any HPHC Specialist	Any licensed specialist	PCP must refer	PCP must refer	PCP must refer	No referral required	No referral required	PCP must refer	PCP must refer	PCP must refer

red font indicates change or clarification	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN		FALLON HEALTH	
PLAN TYPE	PPO		BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK	CHOICENET	HSA ELIGIBLE	NETWORK BLUE NE	HSA ELIGIBLE		HSA ELIGIBLE		HSA ELIGIBLE
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Providers of Service	**HARVARD PILGRIM** providers - Members also have access to a wide range of participating providers through the Private Health Care Systems network while outside of MA, NH and ME	Any licensed provider; any hospital	**HARVARD PILGRIM** providers except in emergencies	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities throughout Massachusetts, southern New Hampshire and southwestern Vermont. ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities throughout Massachusetts, southern New Hampshire and southwestern Vermont. ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
INPATIENT										
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Nothing	20% coinsurance after deductible	Deductible applies then: Tier 1 : $250 Tier 2 :$500 Tier 3 : $1500 per/Admit NOTE-Mental Health/Substance Abuse copay $250	Deductible, then CIF^	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay	Deductible, then CIF^	Semi-private room & board & ancillary services Tier 1: $500 copay, then deductible applies Tier 2: $1500 copay, then deductible applies NOTE-Mental Health/Substance Abuse copay $500	Deductible, then CIF^	$500 copay per admission, then deductible No co-pay or deductible for Mental Hospital/Substance Abuse Facility	Deductible, then CIF^
Physician Services	Nothing	20% coinsurance after deductible	Nothing	Deductible, then CIF^	Nothing	Deductible, then CIF^	Nothing	Deductible, then CIF^	Nothing, after deductible	Deductible, then CIF^

red font indicates change or clarification	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN		FALLON HEALTH	
PLAN TYPE	PPO		BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK	CHOICENET	HSA ELIGIBLE	NETWORK BLUE NE	HSA ELIGIBLE		HSA ELIGIBLE		HSA ELIGIBLE
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Skilled Nursing Facility	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then CIF^ up to 100 days per plan year	Deductible, then covered in full	Deductible, then CIF^	Covered in Full after Deductible, up to 100 days per plan year	Deductible, then CIF^	$500 copay per admission, then deductible Max of 100 days per year.	Deductible, then CIF^
Newborn Well Baby Care (Inpatient)	Nothing	20% coinsurance after deductible	Nothing	Deductible, then CIF^	Nothing	Nothing	Nothing	Deductible, then CIF^	Nothing	Deductible, then CIF^
OUTPATIENT										
Emergency Room Visits for Emergency or Accident Care	$40 copay, waived if admitted	$40 copay, waived if admitted	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	Deductible, then CIF^	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	Deductible, then CIF^	$100 copay, then deductible applies (Inpatient copay applies if admitted)	Deductible, then CIF^	$100 copay, then deductible applies (waived if admitted, then Inpatient copay applies)	Deductible, then CIF^
Outpatient Surgery in a Day Surgery facility or Hospital	Nothing	20% coinsurance after deductible	Deductible applies, then $250 copay per visit	Deductible, then CIF^	Deductible applies, then $250 copay per visit	Deductible, then CIF^	$250 copay per outpatient surgery, then deductible	Deductible, then CIF^	$250 copay per outpatient surgery, then deductible	Deductible, then CIF^
CT, MRI and Pet Scans	Nothing	20% coinsurance after deductible	Deductible applies, then $100 Copay per procedure	Deductible, then CIF^	Deductible, then $100 copay (scheduled outpatient)	Deductible, then CIF^	$100 copay, then Deductible	Deductible, then CIF^	$100 copay, then deducutible	Deductible, then CIF^
Hemodialysis	Nothing	20% coinsurance after deductible	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient Services	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^

red font indicates change or clarification	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN		FALLON HEALTH	
PLAN TYPE	PPO		BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK	CHOICENET	HSA ELIGIBLE	NETWORK BLUE NE	HSA ELIGIBLE		HSA ELIGIBLE		HSA ELIGIBLE
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Physical Therapy	$5 copay per visit	20% coinsurance after deductible	Copay: $20 per visit - Limited to 30 visits per plan year	Deductible, then CIF^ Limited to 30 visits per plan year	$20 copay; up to 60 visits per calendar year (unlimited for autism)	Deductible, then CIF^ up to 60 visits per calendar year (Unlimited for autism)	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year	Deductible, then CIF^	$20 copay. PT / OT Max limit up to 60 visits per plan year	Deductible, then CIF^ Limited to 60 visits per plan year
Office Visits Primary Care Physician	$5 copay per visit	Not covered	$20 copay per visit	Deductible, then CIF^	$20 copay	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care *(Mental Health copays excluded from OOP max)*	$5 copay per visit	20% coinsurance after deductible	$20 copay per visit	Deductible, then CIF^	$20 per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^
Office Visits Specialist	$5 copay per visit	20% coinsurance after deductible	Tier 1 : $30 copay per visit Tier 2: $60 copay per visit Tier 3: $90 copay per visit	Deductible, then CIF^	$60 copay per visit	Deductible, then CIF^	$60 copay per visit	Deductible, then CIF^	$60 copay per visit	Deductible, then CIF^
OB/GYN	$5 copay per visit	20% coinsurance after deductible	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	20% coinsurance after deductible	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	$5 copay per visit; one visit per calendar year. $0 copay for children under 5 years of age Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers	$0 copay - 1 every 2 years	Deductible, then CIF^	$0 copay; one visit every 12 months	$0 copay; one visit every 12 months	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	Deductible, then CIF^	$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers	Deductible, then CIF^ Covered in full - one visit every 12 month period Eyewear discounts available at participating EYEMed providers

red font indicates change or clarification	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN		FALLON HEALTH	
PLAN TYPE	PPO		BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK	CHOICENET	HSA ELIGIBLE	NETWORK BLUE NE	HSA ELIGIBLE		HSA ELIGIBLE		HSA ELIGIBLE
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Pre-Admission Testing -	Nothing	20% coinsurance after deductible	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Nothing	20% coinsurance after deductible	Nothing	Routine OPD, Pre and Post Natal CIF^	Nothing	Nothing for prenatal; all other serviceds Deductible, then CIF*	Nothing for prenatal and postnatal outpatient care	Nothing for prenatal and postnatal outpatient care	Prenatal: $20 copay first visit only; Post // $20 copay per visit	Prenatal: Nothing Postnatal: Deducible then CIF
Dental Services	**Children up to age 14 -** Covered in full for preventative care. **All members** - $5 copay for extraction of impacted teeth and initial emergency treatment.	**Children up to age 14 -** 20% coinsurance after deductible for preventative care. **All members** - 20% coinsurance after deductible for extraction of impacted teeth and initial emergency treatment.	**Preventative dental for children up to age 13** - Tier 1 Copayment per visit up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	**Deductible, then Children up to age 13** - Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	**Children under age 12**: Preventive dental one exam every six months., incl. Cleaning, fluoride treatment and x-rays. **All members**: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed.	**Children under age 12**: Preventive dental one exam every six months., incl. Cleaning, fluoride treatment and x-rays. **All members**: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed. See Outpatient Surgery for benefit information.	**Children under age 12**; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	**Children under age 12**; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	**Family dental coverage:** $10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.	**Family dental coverage:** All services subject to the deductible and then the following cost share: $10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.
OTHER FEATURES										
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	20% coinsurance after deductible	Nothing when medically necessary	Deductible, then CIF^	Nothing when medically necessary	Deductible, then CIF^	Nothing when medically necessary	Deductible, then CIF^	Nothing when medically necessary	Deductible, then CIF^
Home Health Care	Nothing	20% coinsurance after deductible	Member cost sharing depends on types of services provided and tier placement of provider rendering dervices, as listed in the Schedule of Benefits	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^

red font indicates change or clarification

	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN		FALLON HEALTH	
PLAN TYPE	PPO		BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK	CHOICENET	HSA ELIGIBLE	NETWORK BLUE NE	HSA ELIGIBLE		HSA ELIGIBLE		HSA ELIGIBLE
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Hospice Care	Nothing	20% coinsurance after deductible	Same as Home Health Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	20% of equipment cost to HPHC not to exceed a member's expense of $1000,	Deductible, then 20% of equipment cost to HPHC not to exceed a member's expense of $1000	Deductible, then CIF^	Deductible, then CIF^	Deductible, then 20% coinsurance	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^ 20% coinsurance after the deductible for prosthetic limbs which replace, in whole or in part, an arm or leg.	Deductible, then CIF^
Ambulance	Nothing, when medically necessary	Nothing, when medically necessary	Nothing when medically necessary	Deductible, then CIF^	Deductible then covered in full	Deductible, then CIF^	Deductible then covered in full	Deductible, then CIF^	Covered in full when medically necessary	Deductible, then CIF^
Radiation Therapy	Nothing	20% coinsurance after deductible	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Nothing	20% coinsurance after deductible	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	$5 copay per visit, up to $500 per calendar year	20% coinsurance after deductible	$20 copay, 20 visits per plan year	Deductible, then CIF^ 12 visits per plan year	$20 copay per visit. 12 visits maximum per calendar year	Deductible, then CIF^ 12 visits per calendar year	$20 copay per visit; up to 12 visits per calendar year	Deductible, then CIF^ 12 visits per plan year	$20 copay per visit; up to 12 visits per plan year.	Deductible, then CIF^ 12 visits per plan year
Prescription Drugs	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy:**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy:**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy:**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**
(Inpatient drugs paid in full)	Tier 1: $5 copay Tier 2: $10 copay Tier 3: $25 copay up to a 30 day supply **MedImpact Mail Order:** Tier 1: $10 copay Tier 2: $20 copay Tier 3: $75 copay up to a 90 day supply	Tier 1: $5 copay Tier 2: $10 copay Tier 3: $25 copay up to a 30 day supply **No mail order coverage except through** MedImpact Mail Order	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (up to 90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay

red font indicates change or clarification	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN		FALLON HEALTH	
PLAN TYPE	PPO		BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE	BENCHMARK	HIGH DEDUCTIBLE
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK	CHOICENET	HSA ELIGIBLE	NETWORK BLUE NE	HSA ELIGIBLE		HSA ELIGIBLE		HSA ELIGIBLE
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Fitness Benefit	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**
	Fitness reimb up to **$150** per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Fitness reimb up to **$150** per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Fitness reimb up to **$150** per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Fitness reimb up to **$150** per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Up to $300 reimbursement toward health club membership or exercise classes. See plan materials for details. Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $300 reimbursement toward health club membership or exercise classes. See plan materials for details. Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details. JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details. JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment. The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment. The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.

* **Fallon DirectCare** - Members now have access to Acton Medical Associates, Charles River Medical Associates and Southboro Medical Group, Fallon Clinic, Highland Healthcare Associates IPA, Lahey Clinic, Lawrence General IPA, Lowell General PHO, Mount Auburn Cambridge IPA, and Northeast PHO.

****FCHP SelectCare** - Members have access to FCHP Clinic providers, as well as hundreds of private practice physicians in Central, Northern, Eastern and Southeastern, Massachusetts.

Town of Shrewsbury 2019 - 2020 Employee Payroll Agreement

I _____ authorize the Town of Shrewsbury to deduct the premiums designated below from my payroll check.

Pay Frequency	26-Bi-Weekly Town Departments			26-Bi-Weekly Teachers			26-Bi-Weekly School Administrators			21-Bi-Weekly Aides, ABAs, Ext. Day, and Food Svcs.		
Benchmark Plans	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
BC/BS												
Individual	___ $189.97	$284.95	*8260*	___ $189.97	$284.95	*8261*	___ $189.97	$284.95	*8264*	___ $235.20	$352.80	*8263*
Family	___ $509.35	$764.03	*8250*	___ $509.35	$764.03	*8251*	___ $509.35	$764.03	*8254*	___ $630.63	$945.94	*8253*
Tufts												
Individual	___ $191.08	$286.62	*8280*	___ $191.08	$286.62	*8281*	___ $191.08	$286.62	*8284*	___ $236.57	$354.86	*8283*
Family	___ $500.12	$750.18	*8270*	___ $500.12	$750.18	*8271*	___ $500.12	$750.18	*8274*	___ $619.20	$928.80	*8273*
HPHC												
Individual	___ $178.89	$268.34	*8230*	___ $178.89	$268.34	*8231*	___ $178.89	$268.34	*8234*	___ $221.49	$332.23	*8233*
Family	___ $465.97	$698.95	*8210*	___ $465.97	$698.95	*8211*	___ $465.97	$698.95	*8214*	___ $576.91	$865.37	*8213*
Fallon Select												
Individual	___ $93.96	$254.04	*8330*	___ $93.96	$254.04	*8331*	___ $93.96	$254.04	*8334*	___ $116.33	$314.53	*8333*
Family	___ $253.22	$684.63	*8310*	___ $253.22	$684.63	*8311*	___ $253.22	$684.63	*8314*	___ $313.51	$847.63	*8313*
Fallon Direct												
Individual	___ $71.28	$252.72	*8430*	___ $71.28	$252.72	*8431*	___ $71.28	$252.72	*8434*	___ $88.25	$312.89	*8433*
Family	___ $191.91	$680.40	*8410*	___ $191.91	$680.40	*8411*	___ $191.91	$680.40	*8414*	___ $237.60	$842.40	*8413*
HDHP (HSA) Plans	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
BC/BS												
Individual	___ $153.42	$230.12	*8051*	___ $153.42	$230.12	*8061*	___ $153.42	$230.12	*8071*	___ $189.94	$284.91	*8081*
Family	___ $411.88	$617.82	*8052*	___ $411.88	$617.82	*8062*	___ $411.88	$617.82	*8072*	___ $509.94	$764.91	*8082*
Tufts												
Individual	___ $147.88	$221.82	*8053*	___ $147.88	$221.82	*8063*	___ $147.88	$221.82	*8073*	___ $183.09	$274.63	*8083*
Family	___ $387.32	$580.98	*8054*	___ $387.32	$580.98	*8064*	___ $387.32	$580.98	*8074*	___ $479.54	$719.31	*8084*
HPHC												
Individual	___ $138.46	$207.69	*8055*	___ $138.46	$207.69	*8065*	___ $138.46	$207.69	*8075*	___ $171.43	$257.14	*8085*
Family	___ $361.29	$541.94	*8056*	___ $361.29	$541.94	*8066*	___ $361.29	$541.94	*8076*	___ $447.31	$670.97	*8086*
Fallon Select												
Individual	___ $79.13	$213.95	*8057*	___ $79.13	$213.95	*8067*	___ $79.13	$213.95	*8077*	___ $97.97	$264.89	*8087*
Family	___ $213.47	$577.15	*8058*	___ $213.47	$577.15	*8068*	___ $213.47	$577.15	*8078*	___ $264.29	$714.57	*8088*
Fallon Direct												
Individual	___ $60.11	$213.12	*8059*	___ $60.11	$213.12	*8069*	___ $60.11	$213.12	*8079*	___ $74.42	$263.86	*8089*
Family	___ $161.95	$574.20	*8060*	___ $161.95	$574.20	*8070*	___ $161.95	$574.20	*8080*	___ $200.51	$710.91	*8090*
Indemnity Plans	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
HPHC PPO												
Individual	___ $602.77	$602.77	*8160*	___ $602.77	$602.77	*8161*	___ $602.77	$602.77	*8164*	___ $746.29	$746.29	*8163*
Family	___ $1,338.46	$1,338.46	*8150*	___ $1,338.46	$1,338.46	*8151*	___ $1,338.46	$1,338.46	*8154*	___ $1,657.14	$1,657.14	*8153*
Life Insurance	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
Basic Life	___ $1.96	$1.96	*8904*	___ $1.96	$1.96	*8902*	___ $1.96	$1.96	*8905*	$2.42	$2.42	*8903*
Optional Life	___ $_____		*8915*	$_____		*8916*	$_____		*8917*	$_____		*8918*
	Formula: Rate $ _____ x Ins. Total per 1,000 $ _____ x 12 / _____ (pay frequency)											
Voluntary Life	___ $_____		*8930*	___ $_____		*8931*	___ $_____		*8934*	___ $_____		*8933*

Town Only Dental Ins	EMP	TOWN										
Altus Dental	(24 week)											
Individual	___ $23.38	$0.00	*8970*	___ NA			___ NA			___ NA		
Family	___ $60.11	$0.00	*8971*	___			___			___		

I understand that if my premiums are not deducted correctly from my payroll/retirement check it is my responsibility to notify the Town Benefits Administrator, and I will be responsible for all back premiums. I also understand that the Town deducts premium one month in advance of coverage and additional premium due upon initial enrollment will also be deducted from my first payroll/retirement check. I acknowledge that I have received a notice informing me of my right under COBRA (Consolidated Omnibus Budget Reconciliation Act). I also acknowledge that I have received the Town of Shrewsbury's HIPAA Privacy Policy.

EFFECTIVE DATE: _____

SIGNED: _____ **DATED:** _____