

**TOWN OF FALMOUTH
HEALTH INSURANCE PLANS
EMPLOYEE BI-WEEKLY PREMIUMS
FY21**

FY 21 - Benchmark Plans			
Plan	Type	BI-WEEKLY	Monthly
BCBS - Blue Care Elect Preferred PPO	<i>Individual</i>	\$224.20	\$448.40
	<i>SP/SC</i>	\$449.80	\$899.60
	<i>Family</i>	\$540.38	\$1,080.75
BCBS - Network Blue HMO	<i>Individual</i>	\$107.25	\$214.50
	<i>SP/SC</i>	\$216.38	\$432.75
	<i>Family</i>	\$287.88	\$575.75
Harvard Pilgrim - PPO	<i>Individual</i>	\$145.75	\$291.50
	<i>SP/SC</i>	\$285.88	\$571.75
	<i>Family</i>	\$373.38	\$746.75
Harvard Pilgrim - EPO (HMO)	<i>Individual</i>	\$106.50	\$213.00
	<i>SP/SC</i>	\$213.00	\$426.00
	<i>Family</i>	\$284.88	\$569.75
BCBS - Master Health Plus	<i>Individual</i>	\$410.00	\$820.00
	<i>SP/SC</i>	\$821.25	\$1,642.50
	<i>Family</i>	\$1,024.75	\$2,049.50
	<i>Individual</i>	<i>SP/SC</i>	<i>Family</i>
Annual Deductible	\$300	\$600.00	\$900.00

DELTA DENTAL					
MONTHLY			BI-WEEKLY		
<i>Individual</i>	<i>SP/SC</i>	<i>Family</i>	<i>Individual</i>	<i>SP/SC</i>	<i>Family</i>
\$42.00	\$84.00	\$109.00	\$21.00	\$42.00	\$54.50

FY 21 - High Deductible / H.S.A. Qualified Plans			
Plan	Type	BI-WEEKLY	Monthly
BCBS - Blue Care Elect Preferred PPO	<i>Individual</i>	\$187.00	\$374.00
	<i>SP/SC</i>	\$375.60	\$751.20
	<i>Family</i>	\$449.88	\$899.75
BCBS - Network Blue HMO	<i>Individual</i>	\$89.75	\$179.50
	<i>SP/SC</i>	\$181.25	\$362.50
	<i>Family</i>	\$240.88	\$481.75
Harvard Pilgrim - PPO	<i>Individual</i>	\$100.75	\$201.50
	<i>SP/SC</i>	\$205.75	\$411.50
	<i>Family</i>	\$272.88	\$545.75
Harvard Pilgrim - EPO (HMO)	<i>Individual</i>	\$84.00	\$168.00
	<i>SP/SC</i>	\$170.38	\$340.75
	<i>Family</i>	\$226.25	\$452.50
BCBS - Master Health Plus	<i>Individual</i>	N/A	N/A
	<i>SP/SC</i>	N/A	N/A
	<i>Family</i>	N/A	N/A
	<i>Individual</i>	<i>SP/SC</i>	<i>Family</i>
Annual Deductible	\$2,000	\$ 4,000.00	\$ 4,000.00
Health Savings Account-Annual Contribution	<i>Individual</i>	<i>SP/SC</i>	<i>Family</i>
Town will contribute 50% of deductible in the form of H.S.A.*	\$1,000	\$ 2,000.00	\$ 2,000.00
*(To be made in quarterly installments)			

EYEMED					
MONTHLY			BI-WEEKLY		
<i>Individual</i>	<i>SP/SC</i>	<i>Family</i>	<i>Individual</i>	<i>SP/SC</i>	<i>Family</i>
\$7.53	\$14.31	\$21.02	\$3.77	\$7.16	\$10.51