WEST SUBURBAN HEALTH GROUP

RATE SAVER

Effective 07-01-2012

HEALTH PLAN COMPARISON CHART July 1, 2012

FINAL 3/7/12

	HARVARD PILGRIM HEALTH CARE	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
	HMO RATE SAVER	NETWORK BLUE NE OPTIONS TIERED NETWORK HMO RATE SAVER	EPO RATE SAVER (Navigator)	EPO RATE SAVER
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None
Deductible	None	None	None	None
Out-of-Pocket (OOP) Maximum	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family	None	As noted
Family Covered	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)	Member must select	Member must select	No selection required	Member must select
Specialist Referrals	PCP must refer	PCP must refer	No referral required	PCP must refer
Providers of Service	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies Hospital Tiers: Tier 1: Enhanced Tier 2: Standard Tier 3: Basic	**TUFTS HEALTH PLAN** providers except in emergencies	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 17,000 providers and 50 hospitals. ***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

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
INPATIENT				
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	$250 copay	Enhanced: $250 copay Standard: $500 copay Basic: $500 copay Out-of-state copay: $250 NOTE-Mental Health/Substance Abuse copay $250	Semi-private room & board & ancillary services Tier 1: $150 copay Tier 2: $250 copay NOTE-Mental Health/Substance Abuse copay $150	$250 copay per admission ($1,000 out-of-pocket maximum)
Physician Services	Nothing	Nothing (Hospital copay applies)	Nothing	Nothing
Skilled Nursing Facility	$250 copayment for each admission, up to 100 days per year	Nothing up to 100 days per year	Nothing up to 100 days per year	$250 copayment for each admission, up to 100 days per year
Newborn Well Baby Care (Inpatient)	Nothing	Nothing	Nothing	Nothing
OUTPATIENT				
Emergency Room Visits for Emergency or Accident Care	$75 copay (Inpatient copay applies if admitted)	$75 copay (Inpatient copay applies if admitted)	$75 copay (Inpatient copay applies if admitted)	$75 copay (Inpatient copay applies if admitted)
Emergency Care in Doctor's Office	n/a	n/a	n/a	n/a
Outpatient Surgery in a Day Surgery facility or Hospital	$125 copay per outpatient surgery	Enhanced: $150 copay Standard: $250 copay Basic: $250 copay Out-of-State copay $150	$125 copay per outpatient surgery	$125 copay per outpatient surgery
CT, MRI and Pet Scans	Nothing	General Hospitals: Enhanced: $75 copay Standard: $150 copay Basic: $150 Other Providers: $75 copay	$75 copay	Nothing

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BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Hemodialysis	Nothing	Nothing	Nothing	Nothing
Physical Therapy	$20 copay (short-term); up to 90 consecutive days per condition	$45 copay; up to 60 visits per calendar year	Speech and short-term PT/OT $20 copay per visit; 30 visits per calendar year	$20 copay; up to 60 visits per calendar year
Office Visits Primary Care Physician	$20 copay per visit	Enhanced: $15 copay Standard: $25 copay Basic $45 copay Out-of-state copay $15	$20 copay per visit	$20 copay per visit
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care	$20 copay per visit	Enhanced: $15 copay Standard: $25 copay Basic: $45 copay Out-of-state copay: $15 NOTE: Mental Health Care copay $15	$20 copay per visit	$20 copay per visit
Office Visits Specialist	$35 copay per visit	$45 copay per visit	$35 copay per visit	$35 copay per visit
OB/GYN	$20 copay per visit	$15 copay per visit	$20 copay per visit	$20 copay per visit
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	Nothing	Nothing	Nothing

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BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Routine Vision Exam	$20 copay per visit; one visit per calendar year. $0 copay for children under 5 years of age	$0 copay; one visit every 24 months	$20 copay per visit; one visit per calendar year	$0 copay per visit; one visit every 12 months
Pre-Admission Testing -	Nothing	Nothing	Nothing	Nothing
Maternity Care visits	Nothing	Nothing	$20 copay per visit with a maximum of 10 visits for pre and post natal care, then covered in full.	Prenatal: $20 copay first visit only; Post natal: $20 copay per visit
Dental Services	**Children under age 12** - 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.	No coverage	**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.	**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.
OTHER FEATURES				
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary
Home Health Care	Nothing	Nothing	Nothing	Nothing
Hospice Care	Nothing	Nothing	Nothing	Nothing
Durable Medical Equipment	20% of HPHC cost	Nothing up to $750 per calendar year Prosthetics covered in full	80% Covered	Nothing 20% coinsurance for prosthetic limbs which replace, in whole or in part, an arm or leg
Ambulance	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary
Radiation Therapy	Nothing	Nothing	Nothing	Nothing

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BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Chemotherapy	Nothing	Nothing	Nothing	Nothing
Chiropractor Visits *(copays excluded from OOP max)*	12 visit maximum not to exceed $500 per calendar year	$45 copay per visit. 12 visits maximum per calendar year	$20 copay per visit; up to 12 visits per calendar year	$20 copay per visit; up to 12 visits per calendar year not to exceed $500 per calendar year.
Prescription Drugs (Inpatient drugs paid in full)	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $45.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $90.00 copay	Retail Pharmacy: Tier 1: $15.00 copay Tier 2: $30.00 copay Tier 3: $50.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: $30.00 copay Tier 2: $60.00 copay Tier 3: $100.00 copay	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $45.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $90.00 copay	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $45.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $90.00 copay
Fitness Benefit	**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. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Up to **$300** reimbursement toward membership or exercise classes at a health club. 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 per calendar year. See plan materials for details.	It Fits! Program reimburses families up to **$400** per family contract (**$200** 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. Direct Care It Fits reimbursement **$250** / **500.** 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 Aubu

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

The information provided here is an abbreviated description of health plan features. Details of coverage and exclusion are available from each health plan provider. Health plan representatives provided the information for this summary of benefits and th
These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.