

WEST SUBURBAN HEALTH GROUP

Health Plan Comparison Chart July 2009

Effective 07-01-2009

BENEFIT	HARVARD PILGRIM HEALTH CARE			NETWORK BLUE NEW ENGLAND	TUFTS HEALTH PLAN			FALLON COMMUNITY HEALTH PLAN
	EPO	PPO		EPO	EPO	POS		EPO
		IN-NETWORK	OUT-OF-NETWORK			IN-NETWORK	OUT-OF-NETWORK	
	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
Deductible for Non-network Services	None	\$100 per member per year not to exceed \$200 per family per year	\$100 per member per year not to exceed \$200 per family per year	None	Not applicable	\$100 per member per year not to exceed \$200 per family per year	\$100 per member per year not to exceed \$200 per family per year	Not applicable
Coinsurance	None	20%	20%	None	None	20%	20%	None
Out-of Pocket Maximum	None	\$1,600 per member per year not to exceed \$3,200 per family per year (includes deductible)	\$1,600 per member per year not to exceed \$3,200 per family per year (includes deductible)	None	None	\$1,500 per member per year not to exceed \$3,000 per family per year (includes deductible)	\$1,500 per member per year not to exceed \$3,000 per family per year (includes deductible)	
Family Covered	Spouse, unmarried children to age 19, full-time dependent students to age 25	Spouse, unmarried children to age 19; Full-time dependent students to age 25	Spouse, unmarried children to age 19; Full-time dependent students to age 25	Spouse, unmarried children to age 19, full-time dependent students to age 25	Spouse, unmarried children to age 19; Full-time dependent students to age 25	Spouse, unmarried children to age 19; Full-time dependent students to age 25	Spouse, unmarried children to age 19; Full-time dependent students to age 25	
Selection of Primary Care Physician (PCP)	Member must select	Any PCP in network	No requirement	Member must select	Member must select	Any PCP in network	No requirement	Member must select
Specialist Referrals	PCP must approve	Any HPHC Specialist	Any licensed specialist	PCP must approve	PCP must refer	PCP refers within the plan	Any licensed specialist	PCP must refer
Providers of Service	<u>HARVARD PILGRIM</u> providers except in emergencies	Any provider or hospital in the Harvard Pilgrim network	Any licensed provider; any hospital	<u>HMO BLUE</u> providers in all 6 New England states except in emergencies	<u>TUFTS HEALTH PLAN</u> providers except in emergencies	Any provider or hospital in the Tufts network	Any licensed provider; any hospital	<p>**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.</p> <p>*DIRECTCARE - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.</p>
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions

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	EPO	PPO		EPO	EPO	POS		EPO
		IN-NETWORK	OUT-OF-NETWORK			IN-NETWORK	OUT-OF-NETWORK	
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
INPATIENT								
General Hospital (semi-private room and board and ancillary services)	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
Physician Services	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
Skilled Nursing Facility	Nothing up to 100 days per year	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year	Nothing up to 100 days per year	Nothing up to 100 days per year	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year	Nothing up to 100 days per year
Newborn Well Baby Care (Inpatient)	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
OUTPATIENT								
Emergency Room Visits for Emergency or Accident Care	\$30 copay (waived if admitted) in Service Area	\$40 copay, waived if admitted	\$40 copay, waived if admitted	\$25 copay, waived if admitted	\$25 copay, waived if admitted	\$25 copay, waived if admitted	\$25 copay, waived if admitted	\$25 copay, waived if admitted
Outpatient Surgery	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
CT, MRI and Pet Scans	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
Hemodialysis	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
Physical Therapy	\$5 copay (short-term); up to 90 consecutive days per condition	Nothing	20% coinsurance after deductible	\$5 copay; up to 60 visits per calendar year	\$5 copay, short-term	Nothing	20% coinsurance after deductible	\$5 copay up to 20 visits per condition per calendar year
Routine Physical Exams	\$5 copay per visit	\$5 copay per visit	Not covered	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$5 copay per visit
Medical Care	\$5 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$5 copay per visit
Office Visits Specialist	\$5 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$5 copay per visit
Routine GYN Exam	\$5 copay per visit	\$5 copay per visit	Not covered	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit	20% coinsurance after deductible	\$5 copay per visit
Diagnostic X-ray and Lab	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing

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	EPO	PPO		EPO	EPO	POS		EPO
		IN-NETWORK	OUT-OF-NETWORK			IN-NETWORK	OUT-OF-NETWORK	
YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Routine Vision Exam	\$5 copay per visit; one visit per calendar year	\$5 copay, one visit per calendar year Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers	\$5 copay per visit; one visit every 12 months	\$5 copay per visit, on visit per calendar year Eyewear discounts available at participating providers	\$5 copay Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers	\$5 copay per visit, one visit every 12 months
Pre-Admission Testing	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
Maternity Care	Nothing	Nothing	20% coinsurance after deductible	Nothing	\$5 copay per visit with max of 10 visits for pre and post-natal care, then covered in full	Nothing	20% coinsurance after deductible	\$5 copay prenatal first visit only; \$5 copay postpartum each visit; Inpatient maternity covered in full
Dental Services	Children under age 14 - 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 14 - Covered in full for preventative care. All members - \$5 copay for extraction of impacted teeth and initial emergency treatment.	Children under age 14 - 20% coinsurance after deductible for preventative care. All members - 20% coinsurance after deductible for extraction of impacted teeth and initial emergency treatment.	For children under age 12: Preventative dental up to two exams per cal. yr., incl. Cleaning, fluoride treatment and x-rays. For 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.	Preventative dental for children under age 12 , 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.	Not covered. Exceptions: All members ER services following injury; Extraction of teeth	Not covered. Exceptions: All members ER services following injury; Extraction of teeth	Family dental coverage: \$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25-50% discounts available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. MUST use participating dentist.
MENTAL HEALTH								
- Inpatient admissions in a General hospital, Mental Hospital or Alcohol/Drug Facility	After \$250 inpatient deductible, covered as follows:	Covered in full in a General Hospital. Covered in full up to 60 days in a Mental Hospital or Alcohol/Drug facility. Alcohol treatment covered in full up to 30 days per year at a Mental Hospital or Detox facility.	20% coinsurance after deductible at a General Hospital. 20% coinsurance after deductible for up to 60 days in a Mental Hospital or Alcohol/Drug facility. 20% coinsurance after deductible for Alcohol treatment for up to 30 days per year at a Mental Hospital or Detox facility.	In full in a general hospital. Up to 60 days in a psychiatric hospital for non-biologically-based conditions.	Covered in full at a THP designated facility up to 60 days per calendar year	Covered in full in MH Dept of a General Hospital or THP designated facility; limit of 60 days per calendar year.	20% coinsurance after deductible in a MH Dept of a General Hospital or THP designated facility; limit of 60 days per calendar year.	Covered in full in a general or psychiatric hospital

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		IN-NETWORK	OUT-OF-NETWORK			IN-NETWORK	OUT-OF-NETWORK	
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
<p><i>As required by law, coverage for certain mental health disorders is the same as for other medical conditions (biologically-based conditions, rape-related conditions and any MH condition for children to age 19)</i></p>	<p>- Inpatient mental health services in a licensed general hospital-unlimited</p> <p>-Inpatient mental health services in a psychiatric hospital-up to 60 days per member per calendar year</p>			<p>In full for biologically based conditions (includes rape related conditions and any condition for children to age 19).</p>				
<p>- Outpatient Treatment of Mental & Nervous Condition</p>	<p>Group Therapy: \$10 copay</p>	<p>\$5 copay up to 24 visits per calendar year for individual therapy and 25 visits per calendar year for group therapy, with a combined max not to exceed 25 visits per calendar year.</p>	<p>20% coinsurance after deductible for up to 24 visits per calendar year for individual therapy and 25 visits per calendar year for group therapy, with a combined max not to exceed 25 visits per calendar year.</p>	<p>\$5 co-pay for up to 24 visits per calendar year</p>	<p>\$5 copay up to 24 visits per calendar year</p>	<p>\$5 copay up to 24 visits per calendar year</p>	<p>20% coinsurance after deductible for up to 24 visits per calendar year.</p>	<p>\$5 copay per visit</p>
<p><i>As required by law, coverage for certain mental health disorders is the same as for other medical conditions (biologically-based conditions, rape-related conditions and any MH condition for children to age 19)</i></p>	<p>Individual Therapy as follows: Visits 1-8: \$5 copay Visits 9-20: \$25 copay</p>							
SUBSTANCE ABUSE SERVICES								
Inpatient treatment for Substance Abuse	<p>After \$250 deductible, covered in full up to 30 days per year</p>	<p>Covered in full up to 30 days per calendar year</p>	<p>20% coinsurance after deductible for up to 30 days per calendar year</p>	<p>Covered in full up to 30 days per calendar year including alcohol treatment.</p>	<p>Covered in full at a THP designated facility up to 30 day limit per calendar year</p>	<p>Covered in full up to 30 days per calendar year</p>	<p>20% coinsurance after deductible up to 30 days per calendar year</p>	<p>Covered in full for unlimited days for detoxification and for up to 30 days per calendar year for rehabilitation</p>
Outpatient treatment for Substance Abuse	<p>Nothing up to 20 visits per year or \$500 maximum per year in benefit value - whichever is greater</p>	<p>Up to 20 visits or \$500 max per year in benefit value, whichever is greater covered at: Visits 1-8; \$5 copay per individual or group therapy visit. Visits 9-20; 25 copay for individual and \$5 copay for group therapy visit.</p>	<p>20% coinsurance after deductible for up to 20 visits per year or \$500 max per year in benefit value, whichever is greater</p>	<p>Same as outpatient mental health. Separate alcoholism treatment - 8 visits per calendar year</p>	<p>\$5 copay per visit for rehab/detox; up to \$500 max per calendar year</p>	<p>\$5 copay per visit for rehab/detox; up to \$500 max per calendar year</p>	<p>20% coinsurance after deductible; up to \$500 max per calendar year</p>	<p>\$5 copay unlimited visits</p>

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		IN-NETWORK	OUT-OF-NETWORK			IN-NETWORK	OUT-OF-NETWORK	
YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
OTHER FEATURES								
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	Nothing when medically necessary	20% coinsurance after deductible	Nothing when medically necessary	Nothing, when medically necessary	Not covered	Not covered	Nothing, when medically necessary
Home Health Care	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
Hospice Care	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
Durable Medical Equipment	20% of HPHC cost up to \$1,000 per year out-of-pocket. Maximum coverage \$5,000 per member per year.	20% coinsurance, up to out-of-pocket max of \$1,000 per year, max benefit of \$5,000 per year	20% coinsurance, up to out-of-pocket max of \$1,000 per year, max benefit of \$5,000 per year	Nothing up to \$1,500 per calendar year Prosthetics covered in full	20% coinsurance and Tufts covers 80% up to a combined max of \$5,000 per calendar year	20% coinsurance, up to combined max benefit of \$5,000 per year	20% coinsurance, up to combined max benefit of \$5,000 per year	Corrective appliances and DME covered in full up to a limit of \$1,500 per calendar year
Ambulance	Nothing when medically necessary	Nothing, when medically necessary	Nothing, when medically necessary	Nothing when medically necessary	Nothing, when medically necessary	Nothing, when medically necessary	20% coinsurance after deductible, when medically necessary	Nothing, when medically necessary
Radiation Therapy	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing
Chemotherapy	Nothing	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing, when administered by a health care professional
Chiropractor Visits	Not covered	\$5 copay per visit, up to \$500 per calendar year	20% coinsurance after deductible	Not covered	Not covered	\$5 copay per visit, up to 12 visits per calendar year	20% coinsurance after deductible, up to 12 visits per calendar year	\$5 copay per visit, up to 20 visits per calendar year, for treatment of acute musculoskeletal conditions
Prescription Drugs (Inpatient drugs paid in full)	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay up to a 30 day supply Mail Order: (90 day supply) Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$75 copay up to a 90 day supply	Retail Pharmacy: 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	Retail Pharmacy: 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	Retail Pharmacy: Tier 1: \$5.00 copay Tier 2: \$10.00 copay Tier 3: \$25.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$5.00 copay Tier 2: \$10.00 copay Tier 3: \$25.00 copay	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay up to a 30 day supply Mail Order: Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$50 copay up to a 90 day supply	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay up to a 30 day supply Mail Order: Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$50 copay up to a 90 day supply	Retail Pharmacy: No coverage except at PCS participating pharmacies No mail order coverage except through PCS Mail Order	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$15 copay Tier 3: \$35 copay up to a 30 day supply Mail Order: Tier 1: \$10 copay Tier 2: \$30 copay Tier 3: \$105 copay up to a 90 day supply

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	EPO	PPO		EPO	EPO	POS		EPO
		IN-NETWORK	OUT-OF-NETWORK			IN-NETWORK	OUT-OF-NETWORK	SELECTCARE & DIRECTCARE
BENEFIT	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
	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.	Fitness reimbursement up to \$150 per subscriber at a fitness facility per calendar year. Must be an active member of the HPHC and fitness facility for 4 months.	Fitness reimbursement up to \$150 per subscriber at a fitness facility per calendar year. Must be an active member of the HPHC and fitness facility for 4 months.	Up to \$150 reimbursement toward membership or exercise classes at a health club. See plan materials for details.	Fitness reimbursement up to \$150 per subscriber at a fitness facility per calendar year. Must be an active member of the THP and fitness facility for 4 months.	Fitness reimbursement up to \$150 per subscriber at a fitness facility per calendar year. Must be an active member of the THP and fitness facility for 4 months.	Fitness reimbursement up to \$150 per subscriber at a fitness facility per calendar year. Must be an active member of the THP and fitness facility for 4 months.	<i>It Fits!</i> Program reimburses families up to \$400 per family contract (\$200 for individual contracts) to use toward health club memberships, Pilates and yoga classes, Weight Watchers® programs, and local & school sports programs.
		Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to \$150 per calendar year toward your program fees.	Discount at Weight Watchers®	Discount at Weight Watchers®	Discount at Weight Watchers®	Other discounts also available. See plan materials for details.

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.

* 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.

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 the West Suburban Health Group is not responsible for its accuracy.