

West Suburban Health Group Rate Saver Plans - July 2009

	NETWORK BLUE NEW ENGLAND OPTIONS TIERED NETWORK	HARVARD PILGRIM	FALLON COMMUNITY HEALTH PLAN DIRECTCARE & SELECTCARE	TUFTS "NAVIGATOR" TIERED NETWORK
	EPO	EPO	EPO	EPO
	RATE SAVER	RATE SAVER	RATE SAVER	RATE SAVER
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None
Deductible for Non-network Services	None	None	None	None
Coinsurance Out-of-Network	None	None	None	None
Out-of Pocket Maximum	None	\$2,000 Individual \$4,000 Family	None	None
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
Selection of Primary Care Physician (PCP)	Member must select	Member must select	Member must select	No selection required
Specialist Referrals	PCP must approve	PCP must approve	PCP must approve	No referral required
Providers of Service	HMO BLUE providers in all 6 New England states except in emergencies Hospital Tiers: Tier 1: Enhanced Tier 2: Standard Tier 3: Basic	HARVARD PILGRIM 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.	TUFTS HEALTH PLAN providers except in emergencies
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions

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INPATIENT				
General Hospital (semi-private room and board and ancillary services)	Enhanced: \$250 copay Standard: \$500 copay Basic: \$1,000 copay Out-of-state copay: \$250	\$250 copay	\$250 copay (out-of-pocket maximum: 4 copays per year)	Semi-private room & board & ancillary services - Tier 1: \$150 copay Tier 2: \$250 copay
Physician Services	Nothing (Hospital copay applies)	Nothing	Nothing	Nothing
Skilled Nursing Facility	Nothing up to 100 days per year	Nothing up to 100 days per year	Nothing up to 100 days per year	Nothing up to 100 days per year
Newborn Well Baby Care (Inpatient)	Nothing	Nothing	Nothing	Nothing
OUTPATIENT				
Emergency Room Visits for Emergency or Accident Care	\$100 copay (Inpatient copay applies if admitted)	\$75 copay (Inpatient copay applies if admitted) in Service Area	\$75 copay (Inpatient copay applies if admitted)	\$75 copay (Inpatient copay applies if admitted)
Outpatient Surgery	Enhanced: \$150 copay Standard: \$250 copay Basic: \$500 copay of-State copay \$150	\$125 copay per outpatient surgery	\$125 copay	\$125 copay per outpatient surgery
CT, MRI and Pet Scans	General Hospitals: Enhanced: \$75 copay Standard: \$150 copay Basic: \$250 Other Providers: \$75 copay	Nothing	Nothing	\$125 copay
Hemodialysis	Nothing	Nothing	Nothing	Nothing
Physical Therapy	\$45 copay; up to 60 visits per calendar year	\$20 copay (short-term); up to 90 consecutive days per condition	\$20 copay; up to 20 visits per illness or injury per calendar year	Speech and short-term PT/OT \$20 copay per visit
Routine Physical Exams	Enhanced: \$15 copay Standard: \$25 copay Basic \$45 copay of-state copay \$15	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
Medical Care	Enhanced: \$15 copay Standard: \$25 copay Basic: \$45 copay Out-of-state copay: \$15	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit

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Office Visits Specialist	\$45 copay per visit	\$40 copay per visit	\$40 copay per visit	\$40 copay per visit
Routine GYN Exam	Enhanced: \$15 copay Standard: \$25 copay Basic: \$45 copay Out-of-state copay: \$15	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
Diagnostic X-ray and Lab	Nothing	Nothing	Nothing	Nothing
Routine Vision Exam	\$45 copay; one visit per every 24 months	\$20 copay per visit; one visit per calendar year	\$20 copay per visit; one visit every 12 months	\$20 copay per visit; one visit per calendar year
Pre-Admission Testing	Nothing	Nothing	Nothing	Nothing
Maternity Care	Nothing	Nothing	Prenatal: \$20 copay first visit only; Postpartum: \$20 copay per visit	\$20 copay per visit with a maximum of 10 visits for pre and post natal care, then covered in full.
Dental Services	No coverage	Preventative dental for children under age 12 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.	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.	Preventative dental for children under age 12; Periodic oral exam, cleaning, flouride treatment and bitewing x-rays once every six months. Full mouth ex-rays once every 5 years. Periapicals as needed. Must choose a dentist from THP directory.
MENTAL HEALTH				
- Inpatient admissions in a General hospital, Mental Hospital or Alcohol/Drug Facility	Enhanced: \$250 copay Standard: \$500 copay Basic: \$1,000 copay Out-of-state copay: \$250 Up to 60 days admission per calendar year <i>As required by law, coverage for certain mental health disorders is the same as for other medical conditions</i>	After \$250 inpatient deductible, covered as follows: - Inpatient mental health services in a licensed general hospital-unlimited -Inpatient mental health services in a psychiatric hospital-up to 60 days per member per calendar year	Nothing if in a general or psychiatric hospital	\$150 copay per admission at a Tufts Health Plan designated facility Up to 60 days per calendar year

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- Outpatient Treatment of Mental & Nervous Condition <i>As required by law, coverage for certain mental health disorders is the same as for other medical conditions</i>	\$15 copay for up to 24 visits per calendar year	Group Therapy: \$10 copay Individual Therapy as follows: Visits 1-8: \$20 copay Visits 9-20: \$25 copay	\$20 copay per visit	\$15 copay for up to 24 visits per calendar year
SUBSTANCE ABUSE SERVICES				
Inpatient treatment for Substance Abuse	Enhanced: \$250 copay Standard: \$500 copay Basic: \$1,000 copay Out-of-state copay: \$250	After \$250 deductible, covered in full up to 30 days per year	Nothing for unlimited days for detoxification. Up to 30 days per calendar year for rehabilitation.	\$150 copay per admission at a Tufts Health Plan designated facility. Up to 30 days per calendar year
Outpatient treatment for Substance Abuse	Same as outpatient mental health. Separate alcoholism treatment - 8 visits per calendar year	Nothing up to 20 visits per year or \$500 maximum per year in benefit value - whichever is greater	\$20 copay unlimited visits	\$20 copay per visit for rehab/detox. Covered up to \$500 maximum per calendar year
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	Nothing up to \$750 per calendar year Prosthetics covered in full	20% of HPHC cost up to \$1,000 per year out-of-pocket. Maximum coverage \$5,000 per member per year.	Nothing up to a limit of \$1,500 per calendar year for Corrective Appliances & DME.	Member pays 20%; THP pays 80%; up to a combined max of \$5,000 per calendar year
Ambulance	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary
Radiation Therapy	Nothing	Nothing	Nothing	Nothing
Chemotherapy	Nothing	Nothing	Nothing when administered by a health care professional	Nothing
Chiropractor Visits	\$45 copay per visit. 12 visits maximum per calendar year	12 visit maximum not to exceed \$500 per calendar year	\$20 copay per visit; up to 12 visits per calendar year not to exceed \$500 per calendar year.	\$20 copay per visit; up to 12 visits per calendar year not to exceed \$500 per calendar year.

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Prescription Drugs (Inpatient drugs paid in full)	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	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
	Up to \$150 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. 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.	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. Other discounts also available. See plan materials for details.	Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. 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.				