

CCMHG Plan Benefit Comparison

Red font indicates plan design change

revised 1/30/12

Effective 07-01-2012

BENEFIT	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		Master Health Plus Indemnity Plan	HPHC HMO	PPO	
		In-Network	Out-of-Network			IN-NETWORK	OUT-OF-NETWORK
Deductible - applies to: <i>In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to routine office visits or pharmacy. Per plan year (July 1 to June 30) - See plan document for full details</i>	\$250 per member \$750 per family	\$250 per member \$750 per family	\$400 per member \$800 per family	\$250 per member \$750 per family	\$250 per member \$750 per family	\$250 per member \$750 per family	\$400 per member \$800 per family
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. NOTE: Prescription co-pays do not count towards the coinsurance maximum.	\$2,000 per member \$4,000 per family	\$2,000 per member \$4,000 per family	\$3,000 per member	\$2,000 per member \$4,000 per family	\$2,000 per member \$4,000 per family	\$2,000 per member \$4,000 per family	\$3,000 per member
Lifetime Benefit Maximum	None	None	None	None	None	None	None
INPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - Deductible Applies	\$500 copay per admission	\$500 copay per admission	20% coinsurance* Nothing for emergency/accident admissions	\$700 copay per admission	\$500 copay per admission	\$500 copay per admission	20% coinsurance*
Physician Services	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions	Nothing	Nothing	Nothing	20% coinsurance*
Skilled Nursing Facility Deductible Applies	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum	20% coinsurance* to 100 days per calendar year benefit maximum	Nothing	Limit to 100 days per Plan Year - \$500 copay per admission	Limit to 100 days per Plan Year - \$500 copay per admission	20% coinsurance*
Rehabilitation Hospital Deductible Applies	Nothing to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% coinsurance* to 60 days per calendar year benefit maximum	Nothing	Limit to 60 days per Plan Year - \$500 copay per admission	Limit to 60 days per Plan Year - \$500 copay per admission	20% coinsurance*

CCMHG Plan Benefit Comparison

Red font indicates plan design change

revised 1/30/12

Effective 07-01-2012

BENEFIT	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		Master Health Plus Indemnity Plan	HPHC HMO	PPO	
		In-Network	Out-of-Network			IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care - Deductible Applies	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	Nothing for first treatment of accident; \$100 copay for emergency medical care	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)
Emergency Room Visits for Medical Care - Deductible Applies	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)	\$100 copay, waived if admitted
Surgery - Deductible Applies	\$150 copay	\$150 copay	20% coinsurance*	\$150 copay	\$150 copay	\$150 copay	20% coinsurance*
Radiation and Chemotherapy Deductible Applies	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Diagnostic X-ray and Lab - Deductible Applies	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Routine Colonoscopy (without surgery)	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
High Cost Radiology (MRI, CT & PET) - Deductible Applies	\$100 copay	\$100 copay	20% coinsurance*	\$100 copay	\$100 copay	\$100 copay	20% coinsurance*
Hemodialysis - Deductible Applies	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
Physical Therapy	\$20 copay to 60 visits per calendar year	\$20 copay to 100 visits per calendar year	20% coinsurance* to 100 visits per calendar year	\$20 Physician Office \$20 Hospital Setting	Copay Level 1 : \$20 copay per visit, 30 visits per Plan Year	Copay Level 1 : \$20 copay per visit, 30 visits per Plan Year	20% coinsurance*
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery - NO DEDUCTIBLE	\$20/35 co-pay	\$20/35co-pay	20% coinsurance*	\$20 co-pay	Copay Level 1 provider : \$20 copay per visit Copay Level 2 provider : \$35 per visit	Copay Level 1 provider : \$20 copay per visit Copay Level 2 provider : \$35 per visit	20% coinsurance*

CCMHG Plan Benefit Comparison

Red font indicates plan design change

revised 1/30/12

Effective 07-01-2012

BENEFIT	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		Master Health Plus Indemnity Plan	HPHC HMO	PPO	
		In-Network	Out-of-Network			IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Adult Preventative Exam <i>(includes preventative lab)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	\$20 copay	\$20 copay	20% coinsurance*	\$20 copay	Copay Level 1 :\$20 copay	Copay Level 1 :\$20 copay	20% coinsurance*
Well Child Care <i>(includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay (including routine physical exams, immunizations,	\$0 copay (including routine physical exams, immunizations,	20% coinsurance*
Routine GYN Exam <i>(one per calendar year, includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
Routine Mammogram	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
Routine Vision Exam	\$0 copay (once every 12 months)	\$0 copay (once per calendar year)	20% coinsurance* (once per calendar year)	\$0 copay (once every 24 months)	Limited 1 visit per Plan Year - No Charge	Limited 1 visit per Plan Year - No Charge	20% coinsurance*
Specialist Office Visit	\$35 copay	\$35 copay	20% coinsurance*	\$20 copay	Copay Level 2 : \$35 copay	Copay Level 2 : \$35 copay	20% coinsurance*
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse							
Home Health Care Deductible Applies	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Durable Medical Equipment - Deductible Applies	After deductible, member pays 20%, plan pays 80% with no limit	After deductible, member pays 20%, plan pays 80% with no limit	After deductible, member pays 40%, plan pays 60% with no limit	20% coinsurance*	After deductible, member pays 20% until member has paid \$1,000 out of pocket, then plan pays in full. Wigs are covered up to \$350/member/ calendar year when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 20% until member has paid \$1,000 out of pocket, then plan pays in full. Wigs are covered up to \$350/member/ calendar year when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.	After deductible, member pays 20% until member has paid \$1,000 out of pocket, then plan pays in full. Wigs are covered up to \$350/member/ calendar year when needed as a result of any form of cancer, leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.
Ambulance- Deductible Applies	Nothing	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	20% coinsurance*	Nothing	Nothing	Nothing

CCMHG Plan Benefit Comparison

Red font indicates plan design change

revised 1/30/12

Effective 07-01-2012

BENEFIT	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		Master Health Plus Indemnity Plan	HPHC HMO	PPO	
		In-Network	Out-of-Network			IN-NETWORK	OUT-OF-NETWORK
Routine Pediatric Dental (through age 11)	Nothing	All charges	All charges	All charges	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & flouride treatment.	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & flouride treatment.	All charges
Chiropractor Visits	All charges	\$20 copay	20% coinsurance*	\$20 copay	All charges	All charges	All charges
Prescription Drugs	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay Non-formulary drugs All charges	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay
Fitness Benefit	Up to \$150 reimbursement toward membership or exercise classes at a health club. See plan 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 \$150 reimbursement toward membership or exercise classes at a health club. See plan 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 \$150 reimbursement toward membership or exercise classes at a health club. See plan 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.	No Fitness Benefit	Up to \$150 reimbursement per calendar year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.	Up to \$150 reimbursement per calendar year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.	Up to \$150 reimbursement per calendar year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.
<p>*After Deductible</p> <p>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.</p>							