

CCMHG Plan Benefit Comparison Harvard Pilgrim Health Care

Red font indicates plan change

Effective 7-1-2011

HARVARD PILGRIM HEALTH CARE						
BENEFIT	HPHC EPO	HPHC	PPO		PPO RATE SAVER	
		EPO RATE SAVER	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible	None	None	None	\$250 per member \$500 per family per calendar year, applied to eligible expense.	None	\$250 per member \$500 per family per calendar year, applied to eligible expense.
Calendar Year Coinsurance Maximum	None	None	None	\$1,500 per member \$3,000 per family	None	\$1,500 per member \$3,000 per family
Lifetime Benefit Maximum	None	None	None	None	None	None
INPATIENT	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)	Nothing	\$300 per admission	Nothing	20% coinsurance after deductible	\$300 per admission	20% coinsurance after deductible
Physician Services	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing	20% coinsurance after deductible
Skilled Nursing Facility	Nothing up to 100 days per calendar year at a semi- private rate for each benefit	Nothing up to 100 days per calendar year at a semi- private rate for each benefit	Nothing up to 100 days per calendar year at a semi- private rate for each benefit	20% coinsurance after deductible	Nothing up to 100 days per calendar year at a semi-private rate for each benefit	20% coinsurance after deductible

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		EPO RATE SAVER	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Rehabilitation Hospital	Nothing up to 100 days per calendar year at a semi-private rate for each benefit	Nothing up to 100 days per calendar year at a semi-private rate for each benefit	Nothing up to 100 days per calendar year at a semi-private rate for each benefit	20% coinsurance after deductible	Nothing up to 100 days per calendar year at a semi-private rate for each benefit	20% coinsurance after deductible
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care	\$30 co-pay, waived if admitted	\$100 copay, waived if admitted	\$30 co-pay, waived if admitted	\$30 co-pay, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted
Emergency Room Visits for Medical Care	\$30 co-pay, waived if admitted	\$100 copay, waived if admitted	\$30 co-pay, waived if admitted	\$30 co-pay, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted
Surgery	Nothing	\$200 copay. Waived for all colonoscopies	Nothing	20% coinsurance after deductible	\$200 co-pay In-Network. Waived for all colonoscopies	20% coinsurance after deductible
Radiation and Chemotherapy	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing	20% coinsurance after deductible
Diagnostic X-ray and Lab	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing	20% coinsurance after deductible
Hemodialysis	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing	20% coinsurance after deductible

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		EPO RATE SAVER	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Physical Therapy	\$10 co-pay up to 90 consecutive days per condition	\$20 co-pay up to 90 consecutive days per condition	\$10 co-pay up to 90 consecutive days per condition	20% coinsurance after deductible	\$20 co-pay up to 90 consecutive days per condition	20% coinsurance after deductible
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery	\$10 copay	\$20 PCP \$40 Specialist	\$10 copay	20% coinsurance after deductible	\$20 PCP \$40 Specialist	20% coinsurance after deductible
Adult Preventative Exam	\$0 copay	\$0 copay	\$0 copay	20% coinsurance after deductible	\$0 copay	20% coinsurance after deductible
Medical Care/Mental Health Care/Substance Abuse Care	\$10 copay	\$20 PCP \$40 Specialist	\$10 copay	20% coinsurance after deductible	\$20 PCP \$40 Specialist	20% coinsurance after deductible
Well Child Care	\$0 copay (including routine physical exams, immunizations, annual eye exam, school, camp, sports)	\$0 copay (including routine physical exams, immunizations, annual eye exam, school, camp, sports)	\$0 copay (including routine physical exams, immunizations, annual eye exam, school, camp, sports)	20% coinsurance after deductible	\$0 copay (including routine physical exams, immunizations, annual eye exam, school, camp, sports)	20% coinsurance after deductible
Routine GYN Exam (one per calendar year)	\$0 copay	\$0 copay	\$0 copay	20% coinsurance after deductible	\$0 copay	20% coinsurance after deductible
Routine Vision Exam	\$10 copay. \$0 copay for children under 5 years of age	\$20 copay. \$0 copay for children under 5 years of age	\$10 copay \$0 copay for children under 5 years of age	20% coinsurance after deductible	\$20 copay. \$0 copay for children under 5 years of age	20% coinsurance after deductible

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BENEFIT OTHER OUTPATIENT	HPHC EPO YOU PAY	HPHC EPO RATE SAVER YOU PAY	PPO		PPO RATE SAVER	
		IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY	
Visiting Nurse Home Health Care	Nothing	Nothing	Nothing	20% coinsurance after deductible	Nothing	20% coinsurance after deductible
Durable Medical Equipment	Covered in full after copay of 20% of equipment cost to HPHC. 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.	Covered in full after copay of 20% of equipment cost to HPHC. 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.	Covered in full after copay of 20% of equipment cost to HPHC. 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.	20% after coinsurance deductible of equipment cost to HPHC. Member pays a maximum of \$1,000 in coinsurance per calendar year. 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.	Covered in full after copay of 20% of equipment cost to HPHC. 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.	20% after coinsurance deductible of equipment cost to HPHC. Member pays a maximum of \$1,000 in coinsurance per calendar year. 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	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Routine Pediatric Dental	Covered in full: Preventive care for children under age 14. 2 visits per member per calendar year including exam, cleaning, x-rays, & flouride treatment.	Covered in full: Preventive care for children under age 14. 2 visits per member per calendar year including exam, cleaning, x-rays, & flouride treatment.	All charges	All charges	All charges	All charges
Chiropractor Visits	All charges	All charges	All charges	All charges	All charges	All charges

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		EPO RATE SAVER	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs	Retail: (30 day supply) Tier 1: \$5.00 copay Tier 2: \$10.00 copay Tier 3: \$25.00 copay Mail Order: (90 day supply) Tier 1: \$10.00 copay Tier 2: \$20.00 copay Tier 3: \$75.00 copay	Retail: (30 day supply) Tier 1: \$15.00 copay Tier 2: \$30.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$30.00 copay Tier 2: \$60.00 copay Tier 3: \$150.00 copay	Retail: (30 day supply) Tier 1: \$5.00 copay Tier 2: \$10.00 copay Tier 3: \$25.00 copay Mail Order: (90 day supply) Tier 1: \$10.00 copay Tier 2: \$20.00 copay Tier 3: \$75.00 copay	Retail: (30 day supply) Tier 1: \$5.00 copay Tier 2: \$10.00 copay Tier 3: \$25.00 copay Mail Order: (90 day supply) Tier 1: \$10.00 copay Tier 2: \$20.00 copay Tier 3: \$75.00 copay	Retail: (30 day supply) Tier 1: \$15.00 copay Tier 2: \$30.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$30.00 copay Tier 2: \$60.00 copay Tier 3: \$150.00 copay	Retail: (30 day supply) Tier 1: \$15.00 copay Tier 2: \$30.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$30.00 copay Tier 2: \$60.00 copay Tier 3: \$150.00 copay
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.	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.
*After Deductible						
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.						