CCMHG Health Deductible Plan Benefit Comparison - FY18

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Effective 07-01-2017	**BLUE CROSS BLUE SHIELD**			**HARVARD PILGRIM HEALTH CARE**		
		BLUE CARE ELECT PREFERRED PPO			**PPO**	
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible - *applies to: 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***	**$300 per member** **$900 per family**	**$300 per member** **$900 per family**	$400 per member $800 per family	**$300 per member** **$900 per family**	**$300 per member** **$900 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: a separate out-of-pocket maximum for prescription copays added effective July 1, 2015 as required by ACA (in-network only).*	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $3,000 per member	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $3,000 per member
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) - **Deductible Applies**	$500 copay per admission	$500 copay per admission	20% coinsurance* Nothing for emergency/accident admissions	$500 copay per admission	$500 copay per admission	20% coinsurance*
Physician Services	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions	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	Limit to 100 days per Plan Year - $500 copayper admission	Limit to 100 days per Plan Year - $500 copayper 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	Limit to 60 days per Plan Year - $500 copay per admission	Limit to 60 days per Plan Year - $500 copay per admission	20% coinsurance*

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OUTPATIENT HOSPITAL	**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)	$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)	$100 copay, (waived if admitted)	$100 copay, waived if admitted
Surgery - Deductible Applies	**$250 copay**	**$250 copay**	20% coinsurance*	**$250 copay**	**$250 copay**	20% coinsurance*
Radiation and Chemotherapy Deductible Applies	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	20% coinsurance*
Diagnostic X-ray and Lab - Deductible Applies	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	20% coinsurance*
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	20% coinsurance*
High Cost Radiology (MRI, CT & PET) - Deductible Applies	$100 copay	$100 copay	20% coinsurance*	$100 copay	$100 copay	20% coinsurance*
Hemodialysis - Deductible Applies	$0 copay	$0 copay	20% coinsurance*	$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	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**
Surgery - NO DEDUCTIBLE	$20/35 co-pay	$20/35co-pay	20% coinsurance*	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*

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BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Adult Preventative Exam *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	20% coinsurance*
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	$20 copay	$20 copay	20% coinsurance*	Copay Level 1 :$20 copay	Copay Level 1 :$20 copay	20% coinsurance*
Well Child Care *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay (including routine physical exams, immunizations, school, camp, sports)	$0 copay (including routine physical exams, immunizations, school, camp, sports)	20% coinsurance*
Routine GYN Exam *(one per calendar year , includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	20% coinsurance*
Routine Mammogram	$0 copay	$0 copay	20% coinsurance*	$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)	Limited 1 visit per Plan Year - No Charge	Limited 1 visit per Plan Year - No Charge	20% coinsurance*
Specialist Office Visit	**$45 copay**	**$45 copay**	20% coinsurance*	**Copay Level 2 : $45 copay**	**Copay Level 2 : $45 copay**	20% coinsurance*
OTHER OUTPATIENT	**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	20% coinsurance*
Durable Medical Equipment - Deductible Applies	After deductible, member pays 20%, plan pays 80% with no limit. Wigs are covered in full 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%, plan pays 80% with no limit. Wigs are covered in full 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 40%, plan pays 60% with no limit. Wigs are covered in full 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 in full 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 in full 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% coinsurance.
Ambulance- Deductible Applies	Nothing	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	Nothing	Nothing	Nothing
Routine Pediatric Dental (through age 11)	Nothing	All charges	All charges	Covered in full: Preventive care for children under age 12 2 visits per member per	Covered in full: Preventive care for children under age 12 2 visits per member per	All charges

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BENEFIT	NETWORK BLUE HMO	In-Network	Out-of-Network	HPHC HMO	IN-NETWORK	OUT-OF-NETWORK
				plan year including exam, cleaning, x-rays, & flouride treatment.	**plan** year including exam, cleaning, x-rays, & flouride treatment.	

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BENEFIT	NETWORK BLUE HMO	In-Network	Out-of-Network	HPHC HMO	IN-NETWORK	OUT-OF-NETWORK
Chiropractor Visits	All charges	$20 copay	20% coinsurance*	All charges	All charges	All charges
Prescription Drugs	**Retail:** (30 day supply) Tier 1: $10.00 copay **Tier 2: $30.00 copay** **Tier 3: $65.00 copay** **Mail Order:** (90 day supply) **Tier 1: $25.00 copay** **Tier 2: $75.00 copay** **Tier 3: $165.00 copay**	**Retail:** (30 day supply) Tier 1: $10.00 copay **Tier 2: $30.00 copay** **Tier 3: $65.00 copay** **Mail Order:** (90 day supply) **Tier 1: $25.00 copay** **Tier 2: $75.00 copay** **Tier 3: $165.00 copay**	**Retail:** (30 day supply) Tier 1: $10.00 copay **Tier 2: $30.00 copay** **Tier 3: $65.00 copay** **Mail Order:** (90 day supply) **Tier 1: $25.00 copay** **Tier 2: $75.00 copay** **Tier 3: $165.00 copay**	**Retail:** (30 day supply) Tier 1: $10.00 copay **Tier 2: $30.00 copay** **Tier 3: $65.00 copay** **Mail Order:** (90 day supply) **Tier 1: $25.00 copay** **Tier 2: $75.00 copay** **Tier 3: $165.00 copay**	**Retail:** (30 day supply) Tier 1: $10.00 copay **Tier 2: $30.00 copay** **Tier 3: $65.00 copay** **Mail Order:** (90 day supply) **Tier 1: $25.00 copay** **Tier 2: $75.00 copay** **Tier 3: $165.00 copay**	**Retail:** (30 day supply) Tier 1: $10.00 copay **Tier 2: $30.00 copay** **Tier 3: $65.00 copay** **Mail Order:** (90 day supply) **Tier 1: $25.00 copay** **Tier 2: $75.00 copay** **Tier 3: $165.00 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.	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**