WEST SUBURBAN HEALTH GROUP

Effective 07-01-2017

HEALTH PLAN COMPARISON CHART July 1, 2017

red font indicates change or clarification HSA-Qualified HDHP NEW for FY18	HARVARD PILGRIM HEALTH CARE					BLUE CROSS BLUE SHIELD			TUFTS HEALTH PLAN			FALLON COMMUNITY HEALTH PLAN		
PLAN TYPE	**PPO**		**RATE SAVER**	**BENCHMARK**	**HIGH DEDUCTIBLE**	**RATE SAVER**	**BENCHMARK**	**HIGH DEDUCTIBLE**	**RATE SAVER**	**BENCHMARK**	**HIGH DEDUCTIBLE**	**EPO RATE SAVER**	**BENCHMARK**	**HIGH DEDUCTIBLE**
^ CIF = Covered in Full	**IN-NETWORK**	**OUT-OF-NETWORK**	**HMO**	**CHOICENET**	**HSA ELIGIBLE**	**NETWORK BLUE NE OPTIONS TIERED NETWORK HMO**	**NETWORK BLUE NE**	**HSA ELIGIBLE**	**NAVIGATOR EPO**		**HSA ELIGIBLE**			**HSA ELIGIBLE**
BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**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	None	None	None	None	None	None
Deductible - (Benchmark Plans only) applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - *See plan document for full details*	None	IND $100 / FAM $200 per calendar year	None	IND $300 FAM $900	IND $2,000 FAM $4,000 (Non-embedded, plan year deductible, family plan deductible needs to be satisfied before insurance plan kicks in)	None	IND $300 FAM $900	IND $2,000 FAM $4,000	None	IND $300 FAM $900	IND $2,000 FAM $4,000	None	IND $300 FAM $900	IND $2,000 FAM $4,000
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. Effective July 1, 2015, out-of-pocket maximums for prescription copays have been added as required by ACA (in-network only).	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	Not required per the ACA	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year see plan for details	**Medical & RX COMBINED** - $5,000 per member $10,000 per family per plan year year see plan for details	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical & RX COMBINED** - $5,000 per member $10,000 per family per calendar year see plan for details	**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year, see plan for details	**Medical** - $2,000 per member $4,000 per family per plan year **Prescription**- $2,000 per member $4,000 per family per plan year, see plan for details	**Medical & RX COMBINED** - $5,000 per member $10,000 per family per plan year, see plan for details	**Medical & Prescription Combined -** $1,000 Individual $2,000 Family per calendar year	**Medical & Prescription Combined -** $2,000 Individual $4,000 Family per plan year	**Medical & RX COMBINED** - $5,000 per member $10,000 per family per plan year see plan for details
Family Covered	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Any PCP in network	No selection required	Member must select	Member must select	Member must select	Member must select	Member must select	Member must select	No selection required	No selection required	Member must select	Member must select	Member must select	Member must select
Specialist Referrals	Any HPHC Specialist	Any licensed specialist	PCP must refer	PCP must refer	PCP must refer	PCP must refer	PCP must refer	PCP must refer	No referral required	No referral required	PCP must refer	PCP must refer	PCP must refer	PCP must refer

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PLAN TYPE	PPO		RATE SAVER	BENCHMARK	HIGH DEDUCTIBLE	RATE SAVER	BENCHMARK	HIGH DEDUCTIBLE	RATE SAVER	BENCHMARK	HIGH DEDUCTIBLE	EPO RATE SAVER	BENCHMARK	HIGH DEDUCTIBLE
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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Providers of Service	**HARVARD PILGRIM** providers - Members also have access to a wide range of participating providers through the Private Health Care Systems network while outside of MA, NH and ME	Any licensed provider; any hospital	**HARVARD PILGRIM** providers except in emergencies	**HARVARD PILGRIM** providers except in emergencies	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies Hospital Tiers: Tier 1: Enhanced Tier 2: Standard Tier 3: Basic	**HMO BLUE** providers in all 6 New England states except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	**TUFTS HEALTH PLAN** 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 40,000 providers and 60 hospitals. ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals. The network has more than 30,000 providers and 30 hospitals.	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 40,000 providers and 60 hospitals. ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals. The network has more than 30,000 providers and 30 hospitals.	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 40,000 providers and 60 hospitals. ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals. The network has more than 30,000 providers and 30 hospitals.
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
INPATIENT														
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Nothing	20% coinsurance after deductible	$250 copay	Deductible applies then: Tier 1 : $250 Tier 2 :$500 Tier 3 : $1500 per/Admit NOTE-Mental Health/Substance Abuse copay $250	Deductible, then CIF^	Enhanced: $250 copay Standard: $500 copay Basic: $500 copay Out-of-state copay: $250 NOTE-Mental Health/Substance Abuse copay $250	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay	Deductible, then CIF^	Semi-private room & board & ancillary services Tier 1: $150 copay Tier 2: $250 copay NOTE-Mental Health/Substance Abuse copay $150	Semi-private room & board & ancillary services Tier 1: $500 copay, then deductible applies Tier 2: $1500 copay, then deductible applies NOTE-Mental Health/Substance Abuse copay $500	Deductible, then CIF^	$250 copay per admission. No co-pay or deductible for Mental Hospital/Substance Abuse Facility	$500 copay per admission, then deductible No co-pay or deductible for Mental Hospital/Substance Abuse Facility	Deductible, then CIF^
Physician Services	Nothing	20% coinsurance after deductible	Nothing	Nothing	Deductible, then CIF^	Nothing (Hospital copay applies)	Nothing	Deductible, then CIF^	Nothing	Nothing	Deductible, then CIF^	Nothing	Nothing, after deductible	Deductible, then CIF^

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Skilled Nursing Facility	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year	$250 copayment for each admission, up to 100 days per year	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then CIF^ up to 100 days per plan year	Nothing up to 100 days per year	Deductible, then covered in full	Deductible, then CIF^	Covered in full up to 100 days per plan year	Covered in Full after Deductible, up to 100 days per plan year	Deductible, then CIF^	$250 copayment for each admission, up to 100 days per year	$500 copay per admission, then deductible Max of 100 days per year.	Deductible, then CIF^
Newborn Well Baby Care (Inpatient)	Nothing	20% coinsurance after deductible	Nothing	Nothing	Deductible, then CIF^	Nothing	Nothing	Deductible, then CIF^	Nothing	Nothing	Deductible, then CIF^	Nothing	Nothing	Deductible, then CIF^
OUTPATIENT														
Emergency Room Visits for Emergency or Accident Care	$40 copay, waived if admitted	$40 copay, waived if admitted	$75 copay (Inpatient copay applies if admitted) in Service Area	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	Deductible, then CIF^	$75 copay (Inpatient copay applies if admitted)	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	Deductible, then CIF^	$75 copay (Inpatient copay applies if admitted)	$100 copay, then deductible applies (Inpatient copay applies if admitted)	Deductible, then CIF^	$75 copay (waived if admitted then Inpatient copay applies)	$100 copay, then deductible applies (waived if admitted, then Inpatient copay applies)	Deductible, then CIF^
Outpatient Surgery in a Day Surgery facility or Hospital	Nothing	20% coinsurance after deductible	$125 copay per outpatient surgery	Deductible applies, then $250 copay per visit	Deductible, then CIF^	Enhanced: $150 copay Standard: $250 copay Basic: $250 copay Out-of-State copay $150	Deductible applies, then $250 copay per visit	Deductible, then CIF^	$125 copay per outpatient surgery	$250 copay per outpatient surgery, then deductible	Deductible, then CIF^	$125 copay per outpatient surgery	$250 copay per outpatient surgery, then deductible	Deductible, then CIF^
CT, MRI and Pet Scans	Nothing	20% coinsurance after deductible	Nothing	Deductible applies, then $100 Copay per procedure	Deductible, then CIF^	General Hospitals: Enhanced: $75 copay Standard: $150 copay Basic: $150 Other Providers: $75 copay	Deductible, then $100 copay (scheduled outpatient)	Deductible, then CIF^	$75 copay *Copay will not be charged when a member has a cancer diagnosis	$100 copay, then Deductible	Deductible, then CIF^	Nothing	$100 copay, then deducutible	Deductible, then CIF^
Hemodialysis	Nothing	20% coinsurance after deductible	Nothing	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient Services	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Physical Therapy	$5 copay per visit	20% coinsurance after deductible	$20 copay (short-term); up to 90 consecutive days per condition	Copay: $20 per visit - Limited to 30 visits per plan year	Deductible, then CIF^ Limited to 30 visits per plan year	$45 copay; up to 60 visits per calendar year	$20 copay; up to 60 visits per calendar year	Deductible, then CIF^	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year	Deductible, then CIF^	$20 copay. PT / OT Max limit up to 60 visits per calendar year	$20 copay. PT / OT Max limit up to 60 visits per plan year	Deductible, then CIF^
Office Visits Primary Care Physician	$5 copay per visit	Not covered	$20 copay per visit	$20 copay per visit	Deductible, then CIF^	Enhanced: $15 copay Standard: $25 copay Basic $45 copay Out-of-state copay $15	$20 copay	Deductible, then CIF^	$20 copay per visit	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	$20 copay per visit	Deductible, then CIF^
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care *(Mental Health copays excluded from OOP max)*	$5 copay per visit	20% coinsurance after deductible	$20 copay per visit	$20 copay per visit	Deductible, then CIF^	Enhanced: $15 copay Standard: $25 copay Basic: $45 copay Out-of-state copay: $15 NOTE: Mental Health Care copay $15	$20 per visit	Deductible, then CIF^	$20 copay per visit	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	$20 copay per visit	Deductible, then CIF^
Office Visits Specialist	$5 copay per visit	20% coinsurance after deductible	$35 copay per visit	Tier 1 : $30 copay per visit Tier 2: $60 copay per visit Tier 3: $90 copay per visit	Deductible, then CIF^	$45 copay per visit	$60 copay per visit	Deductible, then CIF^	$35 copay per visit	$60 copay per visit	Deductible, then CIF^	$35 copay per visit	$60 copay per visit	Deductible, then CIF^
OB/GYN	$5 copay per visit	20% coinsurance after deductible	$20 copay per visit	$20 copay per visit	Deductible, then CIF^	$45 copay per visit	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	$20 copay per visit	Deductible, then CIF^
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	20% coinsurance after deductible	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	$5 copay per visit; one visit per calendar year. $0 copay for children under 5 years of age Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers	$20 copay per visit; one visit per calendar year. $0 copay for children under 5 years of age	$20 copay per visit; one exam every 2 plan years $0 copay for children under 5 years of age	Deductible, then CIF^	$0 copay; one visit every 24 months	$0 copay; one visit every 12 months	Deductible, then CIF^	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	Deductible, then CIF^	$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers	$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers	Deductible, then CIF^ Eyewear discounts available at participating EYEMed providers

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Pre-Admission Testing -	Nothing	20% coinsurance after deductible	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Nothing	20% coinsurance after deductible	Nothing	Nothing	Routine OPD, Pre and Post Natal CIF^	Nothing	Nothing	Nothing for prenatal; all other serviceds Deductible, then CIF*	Nothing for prenatal and postnatal outpatient care	Nothing for prenatal and postnatal outpatient care	Nothing for prenatal and postnatal outpatient care	Prenatal: $20 copay first visit only; Post natal: $20 copay per visit	Prenatal: $20 copay first visit only; Post // $20 copay per visit	Prenatal: Nothing Postnatal: Nothing after deductible
Dental Services	**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.	**Children under age 12** - 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.	Preventative dental for children up to age 13 - Tier 1 Copayment per visit 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.	Deductible, then CIF^	No coverage	**Children under age 12**: Preventive dental up to two exams per cal. yr., incl. Cleaning, fluoride treatment and x-rays. **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.	**Children under age 12**: Preventive dental up to two exams per cal. yr., incl. Cleaning, fluoride treatment and x-rays. **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. See Outpatient Surgery for benefit information.	**Children under age 12**; Preventative dental, 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.Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	**Children under age 12**; Preventative dental, 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. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	**Children under age 12**; Preventative dental, 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. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	**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.	**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.	**Family dental coverage:** All services subject to the deductible and then the following cost share: $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.
OTHER FEATURES														
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	20% coinsurance after deductible	Nothing when medically necessary	Nothing when medically necessary	Deductible, then CIF^	Nothing when medically necessary	Nothing when medically necessary	Deductible, then CIF^	Nothing when medically necessary	Nothing when medically necessary	Deductible, then CIF^	Nothing when medically necessary	Nothing when medically necessary	Deductible, then CIF^ when medically necessary
Home Health Care	Nothing	20% coinsurance after deductible	Nothing	Member cost sharing depends on types of services provided and tier placement of provider rendering dervices, as listed in the Schedule of Benefits. For example, for services provided by a physician, see "physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Hospice Care	Nothing	20% coinsurance after deductible	Nothing	Same as Home Health Care	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	20% of equipment cost to HPHC not to exceed a member's expense of $1000,	Deductible, then 20% of equipment cost to HPHC not to exceed a member's expense of $1000	20% of HPHC cost	Deductible, then CIF^	Deductible, then CIF^	20% coinsurance Prosthetics covered in full	Deductible, then 20% coinsurance	Deductible, then CIF^	20% coinsurance	Deductible, then CIF^	Deductible, then CIF^	Nothing 20% coinsurance for prosthetic limbs which replace, in whole or in part, an arm or leg.	Deductible, then CIF^ 20% coinsurance after the deductible for prosthetic limbs which replace, in whole or in part, an arm or leg.	Deductible, then CIF^
Ambulance	Nothing, when medically necessary	Nothing, when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Deductible, then CIF^	Nothing when medically necessary	Deductible then covered in full	Deductible, then CIF^	Nothing when medically necessary	Deductible then covered in full	Deductible, then CIF^	Nothing when medically necessary	Covered in full when medically necessary	Deductible, then CIF^
Radiation Therapy	Nothing	20% coinsurance after deductible	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Nothing	20% coinsurance after deductible	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^	Nothing	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	$5 copay per visit, up to $500 per calendar year	20% coinsurance after deductible	$35 copay per visit. 12 visit maximum per calendar year	$20 copay, 20 visits per plan year	Deductible, then CIF^ 12 visits per plan year	$45 copay per visit. 12 visits maximum per calendar year	$20 copay per visit. 12 visits maximum per calendar year	Deductible, then CIF^ 12 visits per plan year	$20 copay per visit; up to 12 visits per calendar year	$20 copay per visit; up to 12 visits per calendar year	Deductible, then CIF^ 12 visits per plan year	$20 copay per visit; up to 12 visits per calendar year.	$20 copay per visit; up to 12 visits per calendar year.	Deductible, then CIF^ 12 visits per plan year
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 **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: $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: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail Pharmacy: Copays AFTER DEDUCTIBLE** Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**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: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail Pharmacy: Copays AFTER DEDUCTIBLE** Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 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: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail Pharmacy: Copays AFTER DEDUCTIBLE** Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 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: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail Pharmacy: Copays AFTER DEDUCTIBLE** Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (up to 90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay

red font indicates change or clarification HSA-Qualified HDHP NEW for FY18	HARVARD PILGRIM HEALTH CARE					BLUE CROSS BLUE SHIELD			TUFTS HEALTH PLAN			FALLON COMMUNITY HEALTH PLAN		
PLAN TYPE	PPO		RATE SAVER	BENCHMARK	HIGH DEDUCTIBLE	RATE SAVER	BENCHMARK	HIGH DEDUCTIBLE	RATE SAVER	BENCHMARK	HIGH DEDUCTIBLE	EPO RATE SAVER	BENCHMARK	HIGH DEDUCTIBLE
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK	HMO	CHOICENET	HSA ELIGIBLE	NETWORK BLUE NE OPTIONS TIERED NETWORK HMO	NETWORK BLUE NE	HSA ELIGIBLE	NAVIGATOR EPO		HSA ELIGIBLE			HSA ELIGIBLE
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	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**	**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 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 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 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 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.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan materials for details.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan materials for details.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details.	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.
	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	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.	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.	The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.	The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.

* **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.