WEST SUBURBAN HEALTH GROUP

Effective 07-01-2019

HEALTH PLAN COMPARISON CHART - July 1, 2019

red font indicates change or clarification	HARVARD PILGRIM HEALTH CARE	
PLAN TYPE	PPO	
^ CIF = Covered in Full	IN-NETWORK	OUT-OF-NETWORK
BENEFIT	**YOU PAY**	**YOU PAY**
Lifetime Benefit Maximum	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*		
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).		
Family Covered	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children until age 26
Selection of Primary Care Physician (PCP)	Any PCP in network	No selection required
Specialist Referrals	Any HPHC Specialist	Any licensed specialist

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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
Pre-existing Conditions	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
Physician Services	Nothing	20% coinsurance after deductible

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Skilled Nursing Facility	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year
Newborn Well Baby Care (Inpatient)	Nothing	20% coinsurance after deductible
OUTPATIENT		
Emergency Room Visits for Emergency or Accident Care	$40 copay, waived if admitted	$40 copay, waived if admitted
Outpatient Surgery in a Day Surgery facility or Hospital	Nothing	20% coinsurance after deductible
CT, MRI and Pet Scans	Nothing	20% coinsurance after deductible
Hemodialysis	Nothing	20% coinsurance after deductible

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Physical Therapy	$5 copay per visit	20% coinsurance after deductible
Office Visits Primary Care Physician	$5 copay per visit	Not covered
Preventive OV - PCP	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
Office Visits Specialist	$5 copay per visit	20% coinsurance after deductible
OB/GYN	$5 copay per visit	20% coinsurance after deductible
GYN-Preventive Office visit	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	20% coinsurance after deductible
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
Pre-Admission Testing -	Nothing	20% coinsurance after deductible
Maternity Care visits	Nothing	20% coinsurance after deductible

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Dental Services	**Children up to age 14 -** Covered in full for preventative care. **All members** - $5 copay for extraction of impacted teeth and initial emergency treatment.	**Children up to age 14 -** 20% coinsurance after deductible for preventative care. **All members** - 20% coinsurance after deductible for extraction of impacted teeth and initial emergency treatment.
OTHER FEATURES		
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	20% coinsurance after deductible
Home Health Care	Nothing	20% coinsurance after deductible
Hospice Care	Nothing	20% coinsurance after deductible
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

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Ambulance	Nothing, when medically necessary	Nothing, when medically necessary
Radiation Therapy	Nothing	20% coinsurance after deductible
Chemotherapy	Nothing	20% coinsurance after deductible
Chiropractor Visits	$5 copay per visit, up to $500 per calendar year	20% coinsurance after deductible
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
Fitness Benefit	**Reimbursement**	**Reimbursement**

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	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. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	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. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®