

COMPARISON CHART CURRENT HMO PLANS

Service	HARVARD PILGRIM	FALLON HMO
Annual Deductible	None	None
Annual out-of-pocket Maximum	None	None
Lifetime Maximum	None	None
Routine Physicals	100% after \$5 copay	100% after \$10 copay
Doctor's Office Visit	100% after \$5 copay	100% after \$10 copay
Hospital Room & Board	100%	100%
Surgery	100%	100%
Diagnostic X-ray & Lab	100%	100%
Emergency Room	\$50 copay per visit (waived if admitted)	100% after \$50 copay
Maternity Care	100%	100% after \$10 copay (first visit only)
Routine Pediatric Care (Office visits for routine physicals and immunizations)	100% after \$5 copay	100% after \$10 copay
Infertility Services and In Vitro Fertilization	Must meet certain criteria before benefits are applicable; \$5 copay	Must meet certain criteria before benefits are applicable; \$10 copay
Outpatient Mental or Nervous Condition	100% after copay: Visits: Copay: 1-24 \$5 each for individual 1-25 \$5 each for group Max 25 visits combined.	100% after \$10 copay
Outpatient Alcoholism Care	100% after copay: Visits: Copay: 1-8 \$5 each 9-20 \$25 each for individual 9-20 \$5 for group Max. of 20 visits or \$500 in benefit value, whichever is greater	100% after \$10 copay
Outpatient Drug Abuse Care	100% after copay: Visits: Copay: 1-8 \$10 each 9-20 \$25 each for individual 9-20 \$5 for group Max. of 20 visits or \$500 in benefit value, whichever is greater	100% after \$10 copay
Skilled Nursing Care; Convalescent	100% in a skilled nursing facility up to 100 days per year	100% in a skilled nursing facility up to 100 days per year
Home Health Care	100% when authorized	100% when authorized
Chiropractic Care	Excluded	Available for the treatment of musculoskeletal conditions only \$10 copay visits 1- 10 \$25 copay visits 11 – 20
Prescription Drugs	\$5 generic \$10 formulary or preferred \$25 non-formulary or non-preferred Mail Order (Up to 90 days) \$10 generic \$20 formulary or preferred \$75 non-formulary or non-preferred	\$5 generic \$15 formulary brand name \$35 non formulary brand name Mail order (up to 90 days) \$10 generic \$30 formulary brand name \$105 non formulary brand name
Physical Therapy	Up to 60 days per illness; \$5 copay per visit	100% after \$10 copay short-term rehab. Only up to 20 visits per illness per calendar year
Inpatient Substance Abuse (includes drug and alcohol abuse)	100% up to annual maximum: - 30 days in hospital or - 60 day-treatment days	100% unlimited for detoxification; up to 30 days rehabilitation; two outpatient rehab. Days may be substituted for each inpatient day up to the limit of 30 inpatient days
Medical Appliances	100% of the 1 st \$2,500	100% up to annual maximum of \$1,500
Health Club Membership	Discounts at over 50 affiliated health clubs	Discounts at many affiliated health clubs
Eyewear	Discounts at participating eyewear retailers	Discounts of 25% for lens and frames at participating retailers
Annual Routine Eye Exam	100% after \$5 copay	100% after \$10 copay

This chart summarizes information about your medical coverage options. If there is any discrepancy between this chart and the information provided by the Health Care Provider's Benefits Summary, the Health Care Provider's Benefit Summary will govern.

COMPARISON CURRENT TUFTS POS & PROPOSED BC/BS PPO BENEFITS

Service	BCBSMA NATIONAL PPO		TUFTS HEALTH PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$250 Individual \$500 Family	\$400 Individual \$800 Family	None	\$500 Individual \$1,000 Family
Annual out-of-pocket Maximum	\$1,000/\$2,000 excluding deductible	\$2,400/\$4,800 excluding deductible	None	\$2,000/\$4,000
Preventive Care	No copay	Plan pays 70% after deductible	100% after \$15 copay	80% after deductible
Doctor's Office Visit	Your copay is \$15 Primary Care/\$20 Specialist per visit	Plan pays 70% after deductible	100% after \$15 copay	80% after deductible
Inpatient Hospitalization	Plan pays 90% after deductible	Plan pays 70% after deductible	100%	80% after deductible
Diagnostic X-ray & Lab	Plan pays 100%	Plan pays 70% after deductible	100%	80% after deductible
Emergency Room	Plan pays 90%, no deductible	Plan pays 90%, no deductible	100% after \$50 copay (waived if admitted)	100% after \$50 copay (waived if admitted)
Outpatient Mental or Nervous Condition	\$15 copay	Plan pays 70%, after deductible	100% after \$15 copay. 24 visits per calendar year max (combined authorized and unauthorized). No day or visit limit on biologically based mental disorders.	80% after deductible. 24 visits per calendar year max (authorized and unauthorized). No day or visit limit on biologically based mental disorders.
Outpatient Alcoholism Care	\$15 copay	Plan pays 70%, after deductible	100% after \$15 copay. \$500 per calendar year max (combined authorized and unauthorized). Detox is unlimited.	80% after deductible. \$500 per calendar year max (authorized and unauthorized). Detox is unlimited.
Outpatient Drug Abuse Care	\$15 copay	Plan pays 70%, after deductible	This benefit is a combined benefit that applies to Outpatient Alcoholism Care and Outpatient Drug Abuse Care	This benefit is a combined benefit that applies to Outpatient Alcoholism Care and Outpatient Drug Abuse Care
Inpatient Mental/Nervous	Plan pays 90% after deductible	Plan pays 70%, after deductible	100% for 60 days annual max. In network and out of network combined. No day or visit limit on biologically based mental disorders.	80% after deductible for 60 days annual max. In network and out of network combined. No day or visit limit on biologically based mental disorders.
Prescription Drugs	Through Caremark: Retail: \$10.00 generic \$20.00 formulary brand name \$35.00 non formulary brand name Mail order (up to 90 day supply) \$20.00 generic \$40.00 formulary brand name \$70.00 non formulary brand	In network only	Through Caremark: Retail: \$10.00 generic \$15.00 formulary brand name \$30.00 non formulary brand name Mail order (up to 90 day supply) \$20.00 generic \$30.00 formulary brand name \$60.00 non formulary brand name	In network only

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