

## CCMHG Health Plan Benefit Comparison - FY23

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.

Effective 07-01-2022

BENEFIT	BLUE CROSS BLUE SHIELD				HARVARD PILGRIM HEALTH CARE		
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		Master Health Plus Indemnity Plan	HPHC HMO	PPO	
		In-Network	Out-of-Network			IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> - applies to: <i>In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, &amp; PET) and Diagnostic Tests &amp; Procedures. Does not apply to routine office visits or pharmacy. Per plan year (July 1 to June 30) - See plan document for full details</i>	\$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	\$300 per member \$900 per family	\$400 per member \$800 per family
<b>Out-of-Pocket (OOP) Maximum</b> - <i>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).</i>	<b>Medical:</b> \$2,000 per member \$4,000 per family <b>Prescription:</b> \$3,000 per member \$6,000 per family	<b>Medical:</b> \$2,000 per member \$4,000 per family <b>Prescription:</b> \$3,000 per member \$6,000 per family	<b>Medical:</b> \$3,000 per member	<b>Medical:</b> \$2,000 per member \$4,000 per family <b>Prescription:</b> \$3,000 per member \$6,000 per family	<b>Medical:</b> \$2,000 per member \$4,000 per family <b>Prescription:</b> \$3,000 per member \$6,000 per family	<b>Medical:</b> \$2,000 per member \$4,000 per family <b>Prescription:</b> \$3,000 per member \$6,000 per family	<b>Medical:</b> \$3,000 per member
<b>Lifetime Benefit Maximum</b>	None	None	None	None	None	None	None
<b>INPATIENT</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
<b>General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - Deductible Applies</b>	\$500 copay per admission	\$500 copay per admission	20% coinsurance* Nothing for emergency/accident admissions	\$700 copay per admission	\$500 copay per admission	\$500 copay per admission	20% coinsurance*
<b>Physician Services</b>	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions	Nothing	Nothing	Nothing	20% coinsurance*
<b>Skilled Nursing Facility Deductible Applies</b>	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	Nothing	Limit to 100 days per Plan Year - \$500 copayper admission	Limit to 100 days per Plan Year - \$500 copayper admission	20% coinsurance*
<b>Rehabilitation Hospital Deductible Applies</b>	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	Nothing	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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		In-Network	Out-of-Network			IN-NETWORK	OUT-OF-NETWORK
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
<b>OUTPATIENT HOSPITAL</b>							
<b>Emergency Room Visits for Emergency or Accident Care - Deductible Applies</b>	\$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)	Nothing for first treatment of accident; \$100 copay for emergency medical care	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)
<b>Emergency Room Visits for Medical Care - Deductible Applies</b>	\$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 or for observation stay)	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)
<b>Surgery - Deductible Applies</b>	\$250 copay	\$250 copay	20% coinsurance*	\$250 copay	\$250 copay	\$250 copay	20% coinsurance*
<b>Radiation and Chemotherapy</b>	Deductible applies	Deductible applies	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
<b>Diagnostic X-ray and Lab - Deductible Applies</b>	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
<b>Routine Colonoscopy (without surgery)</b>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
<b>High Cost Radiology (MRI, CT &amp; PET) - Deductible Applies</b>	\$100 copay	\$100 copay	20% coinsurance*	\$100 copay	\$100 copay	\$100 copay	20% coinsurance*
<b>Hemodialysis - Deductible Applies</b>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
<b>Physical Therapy</b>	\$20 copay to 60 visits per calendar year	\$20 copay to 100 visits per calendar year	20% coinsurance* to 100 visits per calendar year	\$20 copay to 60 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*
<b>PHYSICIAN'S OFFICE</b>							
<b>Surgery - NO DEDUCTIBLE</b>	\$20/\$45 co-pay	\$20/\$45 co-pay	20% coinsurance*	\$45 co-pay	Copay Level 1 provider : \$20 copay per visit Copay Level 2 provider : \$45 per visit	Copay Level 1 provider : \$20 copay per visit Copay Level 2 provider : \$45 per visit	20% coinsurance*

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PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
<b>Adult Preventative Exam</b> <i>(includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
<b>PCP Medical Care/ Mental Health Care/ Substance Abuse Care</b>	\$20 copay	\$20 copay	20% coinsurance*	\$20 copay	Copay Level 1 :\$20 copay	Copay Level 1 :\$20 copay	20% coinsurance*
<b>Well Child Care</b> <i>(includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay (including routine physical exams, immunizations, school, camp, sports)	\$0 copay (including routine physical exams, immunizations, school, camp, sports)	20% coinsurance*
<b>Routine GYN Exam</b> <i>(one per calendar year, includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
<b>Routine Mammogram</b>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
<b>Routine Vision Exam</b>	\$0 copay (once every 12 months)	\$0 copay (once per calendar year)	20% coinsurance* (once per calendar year)	\$0 copay (once every 24 months)	Limited 1 visit per Plan Year - No Charge	Limited 1 visit per Plan Year - No Charge	20% coinsurance*
<b>Specialist Office Visit</b>	\$45 copay	\$45 copay	20% coinsurance*	\$45 copay	Copay Level 2 : \$45 copay	Copay Level 2 : \$45 copay	20% coinsurance*
<b>OTHER OUTPATIENT</b>	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
<b>Visiting Nurse Home Health Care Deductible Applies</b>	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
<b>Durable Medical Equipment - Deductible Applies</b>	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.	20% coinsurance*	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.
<b>Ambulance-Deductible Applies</b>	Nothing	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	20% coinsurance*	Nothing	Nothing	Nothing
<b>Routine Pediatric Dental</b>	Nothing	All charges	All charges	All charges	Covered in full: Preventive care for children up to age 13 2 visits per member per plan year including exam, cleaning, x-rays, & fluoride treatment.	Covered in full: Preventive care for children up to age 13. 2 visits per member per plan year including exam, cleaning, x-rays, & fluoride treatment.	Deductible, then 20% coinsurance

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<b>Chiropractor Visits</b>	All charges	\$20 copay	20% coinsurance*	\$20 copay	All charges	All charges	All charges
<b>Prescription Drugs</b>	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay  Non-formulary drugs All charges	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay
<b>Fitness Benefit</b>	Up to \$150 reimbursement toward membership or exercise classes at a health club; and virtual fitness. 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; and virtual fitness. 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; and virtual fitness. 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.	No Fitness Benefit	Up to \$150 reimbursement per <b>calendar</b> 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 <b>calendar</b> 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 <b>calendar</b> 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