CCMHG Health Deductible Plan Benefit Comparison - FY24

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 07-01-2023	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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BENEFIT	NETWORK BLUE HMO	In-Network	Out-of-Network	HPHC HMO	IN-NETWORK	OUT-OF-NETWORK
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	Deductible applies	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/$45 co-pay	$20/$45co-pay	20% coinsurance*	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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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% 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.
Ambulance- Deductible Applies	Nothing	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	Nothing	Nothing	Emergency transport: notihing Non emergency: 20% coinsurance*
Routine Pediatric Dental	Nothing	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, & flouride treatment.	Covered in full: Preventive care for children up to age 13. 2 visits per member per **plan** year including exam, cleaning, x-rays, & flouride treatment.	Deductible, then 20% coinsurance

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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; 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.	Up to $150 reimbursement per **calendar** year on fees for health and fitness memberships, classes or virtual subscriptions. Must be currently enrolled in HPHC at the time of reimbursement and an active fitness club and HPHC member for at least four months within a calendar year.	Up to $150 reimbursement per **calendar** year on fees for health and fitness memberships, classes or virtual subscriptions. Must be currently enrolled in HPHC at the time of reimbursement and an active fitness club and HPHC member for at least four months within a calendar year.	Up to $150 reimbursement per **calendar** year on fees for health and fitness memberships, classes or virtual subscriptions. Must be currently enrolled in HPHC at the time of reimbursement and an active fitness club and HPHC member for at least four months within a calendar year.

***After Deductible**