Health Insurance Matrix 07/01/2013 - 06/30/2014

Description	Harvard Pilgrim HMO $1,000 Deductible	Harvard Pilgrim HMO 20B	Harvard Pilgrim "Buy-Up" HMO 20A	Harvard Pilgrim PPO
Employee Contributions *Family*	*Monthly* : $271.96 *Bi-Weekly* : $135.98	*Monthly* : $470.64 *Bi-Weekly* :$235.32	*Monthly* : $517.47 *Bi-Weekly* : $258.73	*Monthly* : $796.42 *Bi-Weekly* : $398.21
Employee Contributions *Individual*	*Monthly* : $ 102.60 *Bi-Weekly* : $ 51.30	*Monthly* : $177.60 *Bi-Weekly* : $88.80	*Monthly* : $195.27 *Bi-Weekly* : $97.64	*Monthly* : $300.51 *Bi-Weekly* : $150.26
Office Visits	Primary Care Physician: $25 Specialist: $25	Primary Care Physician: $20 Specialist: $20	Primary Care Physician: $20 Specialist: $20	*In Network* : $20 *Out-of-Network* : 20% co-insurance after deductible
Preventive care - including routine physical, gynecological, well child, school, camp, sports, and premarital examinations	Covered in full	Covered in full	Covered in full	*In Network* : Covered in full *Out-of-Network* : 20% co-insurance after deductible
Routine OB-GYN Exams	$0 (one per calendar year) No PCP referral required	$0 (one per calendar year) No PCP referral required	$0 (one per calendar year) No PCP referral required	*In Network* : $0 *Out-of-Network* : 20% co-insurance after deductible (one per calendar year)
Pap Smears	Included as part of the physical exam	Included as part of the physical exam	Included as part of the physical exam	Included as part of the physical exam
Routine Colonoscopy	Covered in full (Unless physician performs surgery during the procedure)	Covered in full (Unless physician performs surgery during the procedure)	Covered in full (Unless physician performs surgery during the procedure)	*In Network* : Covered in full (Unless physician performs surgery during the procedure) *Out-of-Network* : 20% co-insurance after deductible
Chiropractic Services	$25 co-payment 20 visits per calendar year No referral required	$20 co-payment 20 visits per calendar year No referral required	$20 co-payment 20 visits per calendar year No referral required	*In Network* : $20 (20 visits) *Out-of-Network* : 20% co-insurance after deductible
Diagnostic Laboratory and X-Rays	Covered in full after deductible	Covered in full	Covered in full	*In Network* : Covered in full *Out-of-Network* : 20% co-insurance after deductible
High Tech Radiology - CT Scans, MRIs, and PET Scans	$75 co-payment (No Deductible)	$75 co-payment	$75 co-payment	*In Network* : $75 co-payment *Out-of-Network* : 20% co-insurance after deductible
Dependent Coverage	Dependents are covered up to age 26, regardless of the dependent's financial dependency, student status, marital or employment status.	Dependents are covered up to age 26, regardless of the dependent's financial dependency, student status, marital or employment status.	Dependents are covered up to age 26, regardless of the dependent's financial dependency, student status, marital or employment status.	Dependents are covered up to age 26, regardless of the dependent's financial dependency, student status, marital or employment status.
Emergency Room Visits	$100 co-payment No deductible (waived if admitted or for observation)	$100 co-payment (waived if admitted or for observation)	$100 co-payment (waived if admitted or for observation)	*In Network* : $100/visit (waived if admitted or for observation stay) *Out-of-Network* : $100/visit, no deductible (waived if admitted or for observation stay)

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Mental Health Counseling	$10 co-payment - Group Therapy $25 co-payment - Individual Therapy	$10 co-payment - Group Therapy $20 co-payment - Individual Therapy	$10 co-payment - Group Therapy $20 co-payment - Individual Therapy	*In Network* : $10 co-payment - Group Therapy $20 co-payment - Individual Therapy *Out-of-Network* : 20% co-insurance after deductible
Doctor Selection	HMO Network	HMO Network	HMO Network	*In Network* : PPO *Out-of-Network* : All Others
Pre-Existing Condition	No restriction	No restriction	No restriction	No restriction
Out-of-Area Emergency Care	Seek treatment at the nearest appropriate health care facility	Seek treatment at the nearest appropriate health care facility	Seek treatment at the nearest appropriate health care facility	Seek treatment at the nearest appropriate health care facility
Non-Emergency Hospital Admission	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered
Prescription Drugs *Retail* (Any participating pharmacy)	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3
Prescription Drugs *Mail Order* - 90-Day Supply	$30 - Tier 1 $60 - Tier 2 $150 - Tier 3	$30 - Tier 1 $60 - Tier 2 $150 - Tier 3	$30 - Tier 1 $60 - Tier 2 $150 - Tier 3	$30 - Tier 1 $60 - Tier 2 $150 - Tier 3
Pediatric Preventive Dental Coverage for Dependent Children under 12 years - Two visits per member per calendar year, including examination, cleaning, x-rays and fluoride treatment	Covered in full	Covered in full	Covered in full	*In Network* : Covered in full *Out-of-Network* : 20% co-insurance after deductible

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Calendar Year Deductibles	For some services, you must meet a deductible before services are provided: $1,000 for each member, or $2,000 for all family members covered under the same membership	N/A	N/A	*In Network* : N/A *Out of Network* : $250 for each member, or $500 for all family members covered under the same membership
Calendar Year Out-of-Pocket Maximum: includes all medical copayments, deductible and coinsurance. Does not include prescription copayments	$5,000 for each member, or $10,000 for all family members covered under the same membership	$2,000 for each member, or $4,000 for all family members covered under the same membership	N/A	*In Network* : N/A *Out of Network* : $1,250 for each member, or $2,500 for all family members covered under the same membership
Inpatient Hospital Services - Semi-Private Room	Yes	Yes	Yes	Yes
Inpatient Hospital Services - Private Room	When medically necessary	When medically necessary	When medically necessary	When medically necessary
Inpatient Hospital Care & Surgery	Covered in full after the deductible. $1,000 deductible for each member, or $2,000 for all family members covered under the same membership	$500 co-payment per admission	Covered in full	*In Network* : No cost *Out-of-Network* : 20% co-insurance after deductible
Outpatient (Day) Surgery Hospital or Surgical Facility	Covered in full after deductible	$250 co-pay per visit	Covered in full	*In Network: No cost* *Out-of-Network: 20% co-insurance after deductible*
Outpatient (Day) Surgery Office Setting	Applicable Office Visit Copay Applies	Applicable Office Visit Copay Applies	Applicable Office Visit Copay Applies	*In Network* : Applicable Office Visit Copay Applies *Out-of-Network* : 20% co-insurance after deductible
Lifetime Maximum (Catastrophic Illness)	None	None	None	None
Optical	Vision Exam - One per calendar year, no PCP referral required 35-45% discount on frames and lenses 10-15% discount on contact lenses 25% off laser vision correction at participating Davis Vision Providers (over 600 in New England)	Vision Exam - One per calendar year, no PCP referral required 35-45% discount on frames and lenses 10-15% discount on contact lenses 25% off laser vision correction at participating Davis Vision Providers (over 600 in New England)	Vision Exam - One per calendar year no PCP referral required 35-45% discount on frames and lenses 10-15% discount on contact lenses 25% off laser vision correction at participating Davis Vision Providers (over 600 in New England)	Vision Exam - One per calendar year, no PCP referral required 35-45% discount on frames and lenses 10-15% discount on contact lenses 25% off laser vision correction at participating Davis Vision Providers (over 600 in New England)
Durable Medical Equipment	20% cost share	20% cost share	20% cost Share	20% cost share

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Diabetic Equipment	Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids - Covered in full after deductible Blood glucose monitors, insulin pumps and supplies and infusion devices - Covered in full. (No Deductible) Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips - Subject to the applicable prescription drug co-payment	Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids - Subject to the applicable cost sharing under the durable medical equipment benefit. Blood glucose monitors, insulin pumps and supplies and infusion devices - Covered in full. Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips - Subject to the applicable prescription drug co-payment	Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids - Subject to the applicable cost sharing under the durable medical equipment benefit. Blood glucose monitors, insulin pumps and supplies and infusion devices - Covered in full. Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips - Subject to the applicable prescription drug co-payment	Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids - Subject to the applicable cost sharing under the durable medical equipment benefit. Blood glucose monitors, insulin pumps and supplies and infusion devices - Covered in full. Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips - Subject to the applicable prescription drug co-payment
Wellness Plans	Weight Loss Benefit: $150 per year per individual/family Fitness Benefit: $150 per year per individual/family Appalachian Mountain Club: 20% discount Complementary Alternative Medicine (CAM): 10%-30% discounts on services such as massage therapy, acupuncture, stress reduction, and mind-body therapy	Weight Loss Benefit: $150 per year per individual/family Fitness Benefit: $150 per year per individual/family Appalachian Mountain Club: 20% discount Complementary Alternative Medicine (CAM): 10%-30% discounts on services such as massage therapy, acupuncture, stress reduction, and mind-body therapy	Weight Loss Benefit: $150 per year per individual/family Fitness Benefit: $150 per year per individual/family Appalachian Mountain Club: 20% discount Complementary Alternative Medicine (CAM): 10%-30% discounts on services such as massage therapy, acupuncture, stress reduction, and mind-body therapy	Weight Loss Benefit: $150 per year per individual/family Fitness Benefit: $150 per year per individual/family Appalachian Mountain Club: 20% discount Complementary Alternative Medicine (CAM): 10%-30% discounts on services such as massage therapy, acupuncture, stress reduction, and mind-body therapy
Unique Features	On Line Tools: HPHConnect, Mind the moment, Healthwise, & well, then Allergy Injections: Deductible applies Speech, Hearing, and Language Disorder Treatment: 100% after deductible - no limit Short Term Rehabilitation Therapy (Physical and Occupational): 100% after deductible - Covered up to 30 visits each per calendar year	On Line Tools: HPHConnect, Mind the moment, Healthwise, & well, then Allergy Injections: $5 co-payment Speech, Hearing, and Language Disorder Treatment: $20 copayment - no limit Short Term Rehabilitation Therapy (Physical and Occupational): $20 co-payment - Covered up to 30 visits each per calendar year	On Line Tools: HPHConnect, Mind the moment, Healthwise, & well, then Allergy Injections: $5 co-payment Speech, Hearing, and Language Disorder Treatment: $20 copayment - no limit Short Term Rehabilitation Therapy (Physical and Occupational): $20 co-payment - Covered up to 30 visits each per calendar year	On Line Tools: HPHConnect, Mind the moment, Healthwise, & well, then Allergy Injections: In-Network: $5 co-payment Out-of-Network: 20% coinsurance after deductible Speech, Hearing, and Language Disorder Treatment: In-Network: $20 copayment - no limit Out-of-Network: 20% coinsurance after deductible Short Term Rehabilitation Therapy (Physical and Occupational): In-Network: $20 co-payment - Covered up to 30 visits each per calendar year Out-of-Network: 20% coinsurance after deductible
Hospitals	100% of all Massachusetts hospitals (Also Extensive Network in NH, ME, and RI)	100% of all Massachusetts hospitals (Also Extensive Network in NH, ME, and RI)	100% of all Massachusetts hospitals (Also Extensive Network in NH, ME, and RI)	National network of providers and hospitals