

2008 Medical Plan Comparison

Covered Services	Fallon Community Health Plan	Harvard Pilgrim Healthcare	Tufts Health Plan		
			EPO Premium	POS Premium	
			<u>In-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>
HOSPITALIZATION					All out-of-network services are subject to a deductible & co-insurance.
Room & Board (semi-private)	Covered in full.	Covered in full.	Covered in full.	Covered in full.	20% co-insurance. (3)(4)
Physician/Surgeon Services	Covered in full.	Covered in full.	Covered in full.	Covered in full.	20% co-insurance. (3)(4)
OUTPATIENT CARE					
Routine Physical	\$15 per visit.	\$15 per visit.	\$15 per visit.	\$15 per visit.	20% co-insurance. (3)(4)
Specific Treatment	\$15 per visit.	\$15 per visit.	\$15 per visit.	\$15 per visit.	20% co-insurance. (3)(4)
X-ray & Lab	Covered in full.	Covered in full.	Covered in full.	Covered in full.	20% co-insurance. (3)(4)
MATERNITY					
Prenatal	\$15 per visit. (initial visit only)	\$15 per visit. (initial visit only)	\$15 per visit. (initial visit only)	\$15 per visit. (initial visit only)	20% co-insurance. (3)(4)
Postpartum	Included in initial visit copay.	Included in initial visit copay.	Included in initial visit copay.	Included in initial visit copay.	20% co-insurance. (3)(4)
Hospitalization	Covered in full.	Covered in full.	Covered in full.	Covered in full.	20% co-insurance. (3)(4)
MENTAL HEALTH, ALCOHOL & DRUG REHABILITATION					
Inpatient					
Mental Health	Unlimited in a General or Psychiatric Hospital. (1) (10). Covered in full.	Unlimited in a General Hospital and for up to 60 full days or 120 day treatment visits per calendar year in a Psychiatric Hospital. Covered in full.	Unlimited in a General Hospital, and for up to 60 days in a Psychiatric Hospital. Covered in full.	Unlimited in a General Hospital, and for up to 60 days in a Psychiatric Hospital. Covered in full.	20% co-insurance. Unlimited in a General Hospital, and for up to 60 days in a Psychiatric Hospital. (3)
Substance Abuse	Alcohol/Drug treatment center detoxification-unlimited. Rehabilitation-up to 30 days per year.	Rehabilitation-30 full days or 60 day treatment visits per year. Detoxification is unlimited. (2)	Alcohol/drug treatment center Rehabilitation-up to 30 days per year. Detoxification-unlimited. (2)	Alcohol/drug treatment center Rehabilitation-up to 30 days per year. Detoxification-unlimited. (2)	Substance abuse-20% co-insurance for up to 30 days per year. (2)(3)(4)(8)

2008 Medical Plan Comparison

Covered Services	Fallon Community Health Plan	Harvard Pilgrim Healthcare	Tufts Health Plan		
			EPO Premium	POS Premium	
			<u>In-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>
MENTAL HEALTH, ALCOHOL & DRUG REHABILITATION					All out-of-network services are subject to a deductible & co-insurance.
Outpatient					
Mental Health	\$15 visit, unlimited visits. (1)	No day or visit limits apply for biological illness @\$15/individual visit; \$10/group visit. (1) Max. of 24 individual visits per year @ \$15/visit for non-biological illness. (2)	Unlimited \$15/visit for biological illness. Max. of 24 visits/year @ \$15/visit for non-biological illness. (2)	Unlimited \$15/visit for biological illness. Max. of 24 visits/year @ \$15/visit for non-biological illness. (2)	20% biological illness; 20% co-insurance non-biological illness max. 24 visits/year. Psychiatric day treatments-20% co-insurance (120 visit limit/year). (2)(3)(8)
Substance Abuse	Day treatments/rehabilitation-up to 60 days covered in full per year. Office visits @ \$15/visit. (2)(8)(9)	20 visits or \$500 in benefit value. Group therapy \$15/visit. Individual therapy 1-8 \$15/visit. Visits 9-20 \$25/visit. Day treatment 60 days/year. (2)(13)	Substance abuse day treatments (60 visit limit/year). Outpatient care \$15/visit for up to \$500 per year. (2)(8)	Substance abuse day treatments (60 visit limit/year). Outpatient care \$15/visit for up to \$500 per year. (2)(8)	Substance abuse day treatments-20% co-insurance. 60 visit limit/year.(2)(3)(8)
OTHER SERVICES					
Outpatient Physical Therapy	\$15/visit–20 maximum visits per illness. (1)	Limit of 90 consecutive days per condition \$15/visit outpatient.	\$15/visit. Benefit limits apply.	\$15/visit. Benefit limits apply.	20% co-insurance. Benefit limits apply. (3)(4)
Emergency Care	\$50/visit.(5)(7)	\$50/visit. (5)(7)	\$50/visit. (5)(7)	\$50/visit. (5)(7)	\$50 copay. Responsible for charges above U&C. (12)
Chiropractic Services	Visits 1-20 @\$15/visit. (2)(11)	Visits 1-20 @ \$15/visit. (2)(9)	Visits 1-20 @ \$15/visit. (2)(9)	Visits 1-20 @ \$15/visit. (2)(9)	20% co-insurance. (3)(4)
Durable Medical Equipment	20% copay. \$1,000 out-of-pocket maximum. Covered up to a \$5,000 maximum. Does not apply to prosthetic arms and legs.	20% copay. \$1,000 out-of-pocket maximum. Covered up to a \$5,000 maximum. Does not apply to prosthetic arms and legs.	20% copay. \$1,000 out-of-pocket maximum. Covered up to a \$5,000 maximum. Does not apply to prosthetic arms and legs.	20% copay. \$1,000 out-of-pocket maximum. Covered up to a \$5,000 maximum. Does not apply to prosthetic arms and legs.	20% co-insurance. (3)(4)

2008 Medical Plan Comparison

Covered Services	Fallon Community Health Plan	Harvard Pilgrim Healthcare	Tufts Health Plan		
			EPO Premium	POS Premium	
			In-Network	In-Network	Out-of-Network
OTHER SERVICES					All out-of-network services are subject to a deductible & co-insurance.
Dental Services	Not covered.	Preventive care for children under age 14. Two visits per child per year—covered in full.	Not covered.	Not covered.	Not covered.
Prescription Drugs	\$10 generic prescription \$20 brand name preferred prescription \$35 brand name non-preferred prescription.	\$10 generic prescription \$20 brand name preferred prescription \$35 brand name non-preferred prescription.	\$10 generic prescription \$20 brand name preferred prescription \$35 brand name non-preferred prescription	\$10 generic prescription \$20 brand name preferred prescription \$35 brand name non-preferred prescription	\$10 generic prescription \$20 brand name preferred prescription \$35 brand name non-preferred prescription
	(Discounted mail-in program available up to 90 day supply \$20/\$40/\$105 co-pay)	(Discounted mail-in program available up to 90 day supply \$20/\$40/\$105 co-pay)	(Discounted mail-in program available up to 90 day supply \$20/\$40/\$105 co-pay)	(Discounted mail-in program available up to 90 day supply \$20/\$40/\$105 co-pay)	(Discounted mail-in program available up to 90 day supply \$20/\$40/\$105 co-pay)

Terms and Conditions

1. For specific services when medically necessary.
 2. All benefits are based on a calendar year-maximum.
 3. All benefits paid at 80% after satisfying \$500 deductible if Individual / \$1,500 if Family, to a maximum out-of-pocket expense of \$1,500 if Individual and \$3,000 if Family; then benefits are paid at 100% (the deductible applies from January 1 through December 31).
 4. You must notify Tufts Health Plan prior to any hospitalization or surgical day care not authorized by your personal care physician. If you do not call, you will be responsible for an additional \$1,000 in hospital charges and \$500 in surgical day care charges. These additional charges will not go toward your out-of-pocket limit.
 5. Waived if immediately admitted into hospital.
 6. Your copayments and co-insurance for the treatment of mental health care, alcoholism and substance abuse do not apply toward the out-of-pocket limit.
 7. In order to be covered for emergency care, you or someone acting on your behalf must notify your PCP within 48 hours of the onset emergency.
 8. One inpatient day in a Mental Health/Substance Abuse Facility may be exchanged for two-day treatment visits.
 9. No referral required.
 10. Subject to prior approval requirements.
 11. Referral required by PCP.
 12. U&C – Usual and Customary charge is the amount that medical carrier determines, based upon nationally accepted means of claims payment and the fees most often charged by similar *Providers* for the same service in the geographic area in which it is rendered, to be the reasonable amount for the service
 13. Partial hospitalization services are available up to 60 days per year in lieu of inpatient stays which are capped at 30 days per year.
- NOTE: This comparison is not a Summary Plan Description (SPD). In the event of a conflict between this document, and the SPD, the SPD will be the prevailing authority on coverage question. All care must be medically necessary in order to be covered. Physician referrals for most specialty care services are necessary for HMO/EPO plans. Please call the plan or check your SPD if you have any questions.