2020 Beth Israel Lahey Health
Benefit Comparison

	Domestic & Community HMO Plan		HMO Plus Plan			Tiered POS Plan			
						In-Network			Out-of-network (out of HPHC network) What you pay
	Tier 1	Tier 2	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	
Annual deductible	$500 per member $1,000 per family	$1,000 per member $2,000 per family	None	$1,000 per member $2,000 per family	$1,500 per member $3,000 per family	None	$500 per member $1,000 per family	$1,000 per member $2,000 per family	$2,000 per member $4,000 per family
Annual medical out-of-pocket maximum	$3,500 per member $7,000 per family		$3,500 per member $7,000 per family			$3,000 per member $6,000 per family			
Annual Rx out-of-pocket maximum	$3,000 per member $6,000 per family		$3,000 per member $6,000 per family			$3,000 per member $6,000 per family			
Total annual out-of-pocket maximum	$6,500 per member $13,000 per family		$6,500 per member $13,000 per family			$6,000 per member $12,000 per family			
Preventive care visits	No charge		No charge			No charge			Deductible, then 30% coinsurance
PCP visits	$30 copay	$55 copay ($30 copay for children up to age 19)	$25 copay	$55 copay ($25 copay for children up to age 19)	$85 copay	$20 copay	$30 copay ($20 copay for children up to age 19)	$40 copay	Deductible, then 30% coinsurance
Specialist visits	$40 copay	$65 copay ($40 copay for children up to age 19)	$35 copay	$65 copay ($35 copay for children up to age 19)	$95 copay	$30 copay	$45 copay ($30 copay for children up to age 19)	$60 copay	Deductible, then 30% coinsurance
Outpatient mental health/ substance use (group and individual)	$30 copay		$25 copay			$20 copay			Deductible, then 30% coinsurance
Inpatient mental health/ substance use	Tier 1 Deductible, then 10% coinsurance		No charge			No charge			Deductible, then 30% coinsurance
Emergency room (ER) treatment	$200 copay		$200 copay			$150 copay			
Emergency admission	Tier 1 Deductible, then 10% coinsurance		No charge			No charge			
Urgent care (only HPHC participating urgent care centers)	$40 copay	$90 copay	$35 copay	$85 copay	$125 copay	$30 copay	$70 copay	$110 copay	Deductible, then 30% coinsurance
Hospital inpatient	Deductible, then 10% coinsurance Children up to age 19: Tier 1 deductible, then 10% coinsurance	Deductible, then 30% coinsurance	No charge	Deductible, then 20% coinsurance (waived for children up to age 19)	Deductible, then 40% coinsurance	No charge	Deductible, then 10% coinsurance (waived for children up to age 19)	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance

Harvard Pilgrim Health Care

2020 Beth Israel Lahey Health
Benefit Comparison

	Domestic & Community HMO Plan		HMO Plus Plan			Tiered POS Plan			
						In-Network			Out-of-network (out of HPHC network) What you pay
	Tier 1	Tier 2	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	
Day surgery	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	No charge	Deductible, then 20% coinsurance (waived for children up to age 19)	Deductible, then 40% coinsurance	No charge	Deductible, then 10% coinsurance (waived for children up to age 19)	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
	Children up to age 19: Tier 1 deductible, then 10% coinsurance								
Routine Eye Exam (one exam every 12 months)	$40 copay	$65 copay ($40 copay for children up to age 19)	$35 copay	$65 copay ($35 copay for children up to age 19)	$95 copay ($35 copay for children up to age 19)	$30 Copay	$45 copay ($30 copay for children up to age 19)	$60 copay ($30 copay for children up to age 19)	Deductible, then 30% coinsurance
Short-Term Outpatient Therapy (PT/OT) (Hospital and non-hospital affiliated – combined limit of 72 visits per calendar year)	$40 copay	$65 copay ($40 copay for children up to age 19)	$35 copay	$65 copay ($35 copay for children up to age 19)	$65 copay ($35 copay for children up to age 19)	$30 Copay	$45 copay ($30 copay for children up to age 19)	$45 copay ($30 copay for children up to age 19)	Deductible, then 30% coinsurance
Chiropractic Care (Up to 12 visits per calendar year)	$40 copay	$65 copay	$35 copay	$65 copay	$65 copay	$30 Copay	$45 copay	$45 copay	Deductible, then 30% coinsurance
Skilled Nursing Facility (100 days per calendar year)	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	No Charge			No Charge			Deductible, then 30% coinsurance
	Children up to age 19: Tier 1 deductible, then 10% coinsurance								
Lab/X-ray/diagnostic services and High-end radiology (MRI, CT, PET)									
In physician's office or non-hospital affiliated facility	No charge	$75 copay	No charge	$75 copay (waived for children up to age 19)	$75 copay	No charge	$75 copay (waived for children up to age 19)	$75 copay	Deductible, then 30% coinsurance
In hospital or hospital affiliated facility	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance		Deductible, then 20% coinsurance (waived for children up to age 19)	Deductible, then 40% coinsurance		Deductible, then 10% coinsurance (waived for children up to age 19)	Deductible, then 20% coinsurance	
	Children up to age 19: Tier 1 deductible, then 10% coinsurance								
Prescription drugs									
BIDMC Pharmacy, home delivery service, and select Lahey outpatient pharmacies	$5 (30-day supply), $10 (90-day supply)								
30-day supply CVS Caremark: In-Network Pharmacies	$15 (Generic), $35 (Preferred brand), $55 (Non-preferred brand)								
90-day supply CVS Caremark: In-Network Pharmacies	$30 (Generic), $70 (Preferred brand), $165 (Non-preferred brand)								

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Please refer to the Schedule of Benefits and Benefit Handbook for details and a complete list of benefits.
The Schedule of Benefits and Benefit Handbook govern in any case in which the information in this document is different.