WEST SUBURBAN HEALTH GROUP - PPO and POS PLAN BENEFITS

Effective 7/1/2008

PLAN FEATURES	HARVARD PILGRIM PPO	TUFTS POS
GENERAL		
Lifetime Maximum	None	None
Deductible for Non-Network Services	$100 per member per year not to exceed $200 per family per year.	$100 per member per year not to exceed $200 per family per year.
Coinsurance Out of Network	20%	20%
Out-of-Pocket Maximum	$1,600 per member per year not to exceed $3,200 per family per year (includes deductible)	$1,500 per member per year not to exceed $3,000 per family per year.
Family Covered	Spouse, unmarried children to age 19; Full-time dependent students to age 25.	Spouse, unmarried children to age 19; Full-time dependent students to age 25.
Selection of Primary Care Physician (PCP)	No requirement to select a primary care provider.	In-network: Any PCP in the network. Non-network: No requirement.
Specialist Referrals	In network: Any Harvard Pilgrim specialist. Non-network: Any licensed specialist.	In-network: PCP refers within plan. Non-network: Any licensed specialist.
Hospital Selection	In-network: Any hospital in the Pilgrim network. Non-network: Any hospital.	In-network: Any hospital in the Tufts network. Non-network: Any hospital.
Eyewear	Discounts available at participating providers	Discounts available at participating providers

For benefits with day or visit limits, in-network and out-of-network benefits are combined.

This is an abbreviated description of plan benefits. Details of coverage and exclusions are available from each health plan provider. Health plan representatives provided the information in this summary. The West Suburban Health Group is not responsible for the accuracy of this summary of benefits.

PLAN BENEFITS	HARVARD PILGRIM PPO		TUFTS POS	
INPATIENT SERVICES	**In-Network**	**Non-Network**	**In-Network (Authorized)**	**Non-Network (Unauthorized)**
General Hospital	Covered in full.	Covered at 80% after deductible.	Covered in full.	Covered at 80% after deductible.
Skilled Nursing Facility, Disability and Rehab Facility	Covered in full up to 100 days per year.	Covered at 80% after deductible up to 100 days per year.	Covered in full up to 100 days per calendar year.	Covered at 80% after deductible up to 100 days per calendar year.
Psychiatric, Detox Facility, Alcohol and Drug Facility	Covered in full up to 30 days per year, substance abuse; 60 days per year, mental health.	Covered at 80% after deductible. Up to 30 days per year, substance abuse; 60 days per year, mental health.	Covered in full up to 30 days per calendar year, substance abuse; 60 days per calendar year, mental health.	Covered at 80% after deductible. Up to 30 days per calendar year, substance abuse; 60 days per calendar year, mental health.
Physicians/Covered Professional Providers	Covered in full.	Covered at 80% after deductible.	Covered in full.	Covered at 80% after deductible.
OUTPATIENT (except mental health)				
Initial Accident Care	Covered in full if admitted. If not admitted, $40 co-pay.	In full if admitted. If not admitted, $40 co-pay.	Covered in full if admitted. If not admitted, $25 co-pay.	Covered in full if admitted. If not admitted, $25 co-pay.
Initial Emergency Care	Covered in full, if admitted. If not admitted, $40 co-pay.	Covered in full if admitted. If not admitted, $40 co-pay.	Covered in full if admitted. If not admitted, $25 co-pay.	Covered in full if admitted. If not admitted, $25 co-pay.
Outpatient Surgery & Related Anesthesia	Covered in full.	Covered at 80% after deductible.	Covered in full.	Covered at 80% after deductible.
Radiation, X-Ray, Chemotherapy	Covered in full.	Covered at 80% after deductible.	Covered in full.	Covered at 80% after deductible.
Diagnostic X-Ray and Lab	Covered in full.	Covered at 80% after deductible.	Covered in full.	Covered at 80% after deductible.

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PLAN BENEFITS	**HARVARD PILGRIM PPO**		**TUFTS POS**	
OUTPATIENT (except Mental Health) *Continued*	**In-Network**	**Non-Network**	**In-Network (Authorized)**	**Non-Network (Unauthorized)**
Medical Services, Dialysis, & Physical Therapy	Covered in full.	Covered at 80% after deductible.	Covered in full. See plan for details.	Covered at 80% after deductible. See plan for details.
Dental Surgery in Surgeon's Office	Covered in full after $5 co-pay per visit.	Covered at 80% after deductible	Not covered	Not covered
2nd & 3rd Surgical Opinions	Covered in full after $5 co-pay per visit.	Covered at 80% after deductible	Covered in full after $5 co-pay per visit.	Covered at 80% after deductible
Medical Office Visits	Covered in full after $5 co-pay per visit.	Covered at 80% after deductible	Covered in full after $5 co-pay per visit.	Covered at 80% after deductible
Physical Therapist	Covered in full up to 90 consecutive days per condition	Covered at 80% after deductible up to 90 days (combined with In-Network benefit)	Covered with a $5 co-pay. See plan for details, under physical therapy.	Covered after deductible and coinsurance. See plan for details, under physical therapy.
Well-Child	Covered in full after $5 co-pay per visit.	Covered at 80% after deductible	Covered in full after $ 5 co-pay per visit.	Covered at 80% after applicable deductible.
Adult Routine Physicals	Covered in full after $5 co-pay per visit.	Not covered.	Covered in full after $5 co-pay per visit.	Covered at 80% after applicable deductible.
Annual Gynecologic Exam	Covered in full after $5 co-pay per visit. Females over 18, one per year.	Not covered.	Covered in full after $5 co-pay per visit.	Covered at 80% after applicable deductible.
Mandated Cardiac Rehab	Covered in full.	Covered at 80% after deductible.	Covered in full.	Covered at 80% after deductible.
Home Health Care	Covered in full.	Covered at 80% after deductible.	Covered in full.	Covered at 80% after deductible.

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OUTPATIENT (except Mental Health) *Continued*	**In-Network**	**Non-Network**	**In-Network (Authorized)**	**Non-Network (Unauthorized)**
Private Duty Nursing (medically necessary)	Covered in full.	Covered at 80% after deductible.	Not covered.	Not covered.
Durable Medical Equipment (DME)	Maximum benefit of $5000 per member per year subject to 20% co-insurance up to out-of-pocket max. of $1,000 per year.	Maximum benefit of $5000 per member per year subject to 20% co-insurance up to out-of-pocket max. of $1,000 per year.	Tufts Health Plan pays 80% and Member pays 20% up to a combined maximum of $5,000 per calendar year.	Covered at 80% after deductible.
Ambulance	Covered in full.	Covered in full.	Covered in full, when medically necessary.	Covered at 80% after deductible, when medically necessary.
Annual Eye Exam	Covered in full after $5 co-pay.	Covered at 80% after deductible.	Covered in full after $5 co-pay.	Covered at 80% after applicable deductible.
Chiropractic Care	Covered in full after $5 co-pay per visit (up to $500 per calendar year)	Covered at 80% after deductible	Covered in full after $5 co-pay per visit (up to 12 visits per calendar year).	Covered at 80% after deductible, (up to 12 visits per calendar year).
Dental Services – Preventive care for children under age 14; Extraction of Impacted Teeth & Initial Emergency Treatment	Covered in full (pediatric); In full after a $5 co-pay (extraction, emergency treatment)	Covered at 80% after deductible	Not covered Exceptions: ER services following injury. Extraction of teeth.	Not covered Exceptions: ER services following injury. Extraction of teeth.

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PLAN BENEFITS	HARVARD PILGRIM PPO		TUFTS POS	
MENTAL HEALTH SERVICES	**In-Network**	**Non-Network**	**In-Network (Authorized)**	**Non-Network (Unauthorized)**
Inpatient in a General Hospital *As required by law, coverage for certain mental health disorders is the same as for other medical conditions.*	Covered in full.	Covered at 80% after deductible.	Covered in full.	Covered up to 60 days per calendar year, subject to deductible and coinsurance.
Inpatient in Mental Hospital or Alcohol/Drug Facility *As required by law, coverage for certain mental health disorders is the same as for other medical conditions.*	Covered in full up to 60 days.	Covered at 80% after deductible. Up to 60 days.	Covered in full in Tufts Health Plan designated facility as well as in a MH Dept. of a general hospital; limit of 60 days per calendar year.	Covered at 80% after deductible, limit of 60 days per calendar year.
Inpatient Alcohol Treatment in Mental Hospital/Detox. Facility	Covered in full up to 30 days per year.	Covered at 80% after deductible up to 30 days per year.	Covered in full at a Tufts Health Plan designated facility; 30 day limit per calendar year.	Covered at 80% after deductible up to 30 days per calendar year.

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PLAN BENEFITS	**HARVARD PILGRIM PPO**		**TUFTS POS**	
MENTAL HEALTH SERVICES *Continued*	**In-Network**	**Non-Network**	**In-Network (Authorized)**	**Non-Network (Unauthorized)**
Outpatient Treatment of Mental Conditions *As required by law, coverage for certain mental health disorders is the same as for other medical conditions.*	$5 co-pay per visit for up to 24 visits per calendar year for individual therapy and 25 visits per calendar year for group therapy, with a combined maximum not to exceed 25 individual and group therapy visits per calendar year.	Covered at 80% after deductible for up to 24 visits per calendar year for individual therapy and 25 visits per calendar year for group therapy, with a combined maximum not to exceed 25 individual and group therapy visits per calendar year.	$5 co-pay per visit for up to 24 visits per calendar year.	Covered at 80% after deductible and up to 24 visits per calendar year.
Outpatient Treatment for Alcohol/Drug Abuse	Up to 20 visits or $500 in benefit value, whichever is greater. Visits 1-8: $5 co-pay per individual or group therapy visit. Visits 9-20: $25 co-pay for individual and $5 co-pay for group.	Up to 20 visits per year or $500 in benefit value, whichever is greater covered at 80% after deductible.	After $5 co-pay per visit, covered in full up to $500 per calendar year.	Covered at 80% after deductible. Up to $500 per calendar year.

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PLAN BENEFITS	HARVARD PILGRIM PPO		TUFTS POS	
FITNESS				
Fitness Program	Discounts at IFCN-affiliated clubs. Discount at *Weight Watchers.* Fitness reimbursement up to $150 per subscriber at a Fitness facility. Must be a member of HPHC for at least 4 months and a member at the health facility for at least 4 months to be eligible. See plan for details.		Multiple discount options at participating fitness centers. Discount at *Weight Watchers*. Fitness reimbursement up to $150 per subscriber at a fitness facility after 4 months as Tufts member and 4 months with fitness facility. Discounts available at participating health clubs. See plan materials for details.	
PRESCRIPTION DRUGS	**In-Network**	**Non-Network**	**In-Network (Authorized)**	**Non-Network (Unauthorized)**
Retail pharmacy (*30-day supply*)	Tier 1: $5 co-pay Tier 2: $10 co-pay Tier 3: $25 co-pay	Tier 1: $5 co-pay Tier 2: $10 co-pay Tier 3: $25 co-pay	Tier 1: $5 co-pay Tier 2: $10 co-pay Tier 3: $25 co-pay	No coverage except at PCS participating pharmacies
Mail Order (*90-day supply*)	*MedImpact Mail Order* Tier 1: $10 co-pay Tier 2: $20 co-pay Tier 3: $75 co-pay	No mail order coverage except through MedImpact Mail Order.	*PCS Mail Order* Tier 1: $10 co-pay Tier 2: $20 co-pay 90 day supply) Tier 3: $50 co-pay (90-day supply)	No mail order coverage except through PCS Mail Order.

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