Harvard Pilgrim Health Care | Beth Israel Lahey Health

# 2023 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** | None | $1,000 per member<br>$2,000 per family | None | $1,000 per member<br>$2,000 per family | $2,500 per member<br>$5,000 per family | None | $500 per member<br>$1,000 per family | $2,000 per member<br>$4,000 per family | $2,000 per member<br>$4,000 per family |
| **Annual medical out-of-pocket maximum** | $3,500 per member<br>$7,000 per family | | $3,500 per member<br>$7,000 per family | | | $3,000 per member<br>$6,000 per family | | | |
| **Annual Rx out-of-pocket maximum** | $3,000 per member<br>$6,000 per family | | $3,000 per member<br>$6,000 per family | | | $3,000 per member<br>$6,000 per family | | | |
| **Total annual out-of-pocket maximum** | $6,500 per member<br>$13,000 per family | | $6,500 per member<br>$13,000 per family | | | $6,000 per member<br>$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) | $110 copay | $20 copay | $30 copay ($20 copay for children up to age 19) | $75 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) | $120 copay | $30 copay | $45 copay ($30 copay for children up to age 19) | $100 copay | Deductible, then 30% coinsurance |
| **Outpatient mental health/substance use disorder treatment (group and individual)** | $30 copay | | $25 copay | | | $20 copay | | | Deductible, then 30% coinsurance |
| **Inpatient mental health/substance use disorder treatment** | 10% coinsurance | | No charge | | | No charge | | | Deductible, then 30% coinsurance |
| **Emergency room (ER) treatment** | $200 copay | | $200 copay | | | $150 copay | | | |
| **Emergency admission** | 10% coinsurance | | No charge | | | No charge | | | |
| **Urgent care (only HPHC participating urgent care centers)** | $40 copay | $90 copay ($40 copay for children up to age 19) | $35 copay | $85 copay ($35 copay for children up to age 19) | $125 copay | $30 copay | $70 copay ($30 copay for children up to age 19) | $110 copay | Deductible, then 30% coinsurance |
| **Hospital inpatient** | 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: 10% coinsurance | | | | | | | | |

* If you live 20 or more miles from a Tier 1 BILH primary care provider (PCP) and you live within Harvard Pilgrim's enrollment area (MA, ME, NH, CT, and certain areas of RI, VT and NY), you and your covered dependents may participate in the Out of Area version of this plan. Under the HMO Plus Out of Area plan, you can receive services from a Tier 2 hospital, doctor or other clinician and pay the Tier 1 benefit level. To learn more about the HMO Plus Out of Area plan, visit harvardpilgrim.org/bilh or contact your organization's benefits department.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company

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| | | | | | | 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** | 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: 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) | $120 copay ($35 copay for children up to age 19) | $30 copay | $45 copay ($30 copay for children up to age 19) | $100 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) | | $30 copay | $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 | | $35 copay | | $65 copay | $30 copay | | $45 copay | Deductible, then 30% coinsurance |
| **Skilled Nursing Facility (100 days per calendar year)** | 10% coinsurance | | No charge | | | No charge | | | Deductible, then 30% 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 (waived for children up to age 19) | 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** | 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: 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), $40 (Preferred brand), $60 (Non-preferred brand) | | | | | | | | |
| **90-day supply CVS Caremark: In-Network Pharmacies and Mail Order** | $30 (Generic), $80 (Preferred brand), $180 (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.