

MINUTEMAN NASHOBA HEALTH GROUP BENEFIT COMPARISON
EFFECTIVE JUNE 1, 2008

BENEFIT	FCHP DIRECTCARE * EPO	FCHP SELECTCARE * EPO	HARVARD PILGRIM HEALTH CARE EPO	TUFTS EPO	TUFTS POS
Deductible	Not applicable	Not applicable	Not applicable	Not applicable	Deductible: \$200/member /calendar year, not to exceed \$400 per family
Out-of-Pocket maximum on Unauthorized (non-network) services.	Not applicable	Not applicable	Not applicable	Not applicable	Out-of pocket max. (includes coinsurance and deductible): \$2,200/member/calendar year, not to exceed \$4,400 per family
OUTPATIENT					
Diagnostic Doctor Visit	\$5 co-pay	\$5 co-pay	\$10 co-pay	\$10 co-pay	Authorized: \$10 co-pay Unauthorized: 80% coverage after deductible
Chiropractic Benefit	Up to 20 visits per calendar year, for the treatment of acute musculoskeletal conditions \$5 co-pay per visit	Up to 20 visits per calendar year, for the treatment of acute musculoskeletal conditions \$5 co-pay per visit	No Coverage	Spinal manipulation only. \$10 co-pay, maximum of 12 visits per calendar year	Spinal manipulation only. Authorized: \$10 co-pay, maximum of 12 visits per calendar year Unauthorized: 80% coverage after deductible, 12 visits per yr.
Hospital ER	\$25 co-pay, waived if admitted	\$25 co-pay, waived if admitted	\$50 co-pay, waived if admitted	\$50 co-pay, waived if admitted	\$50 co-pay, waived if admitted
Outpatient Mental Health	Unlimited mental health visits: \$5 co-pay per visit	Unlimited mental health visits: \$5 co-pay per visit	\$10 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 As required by law, coverage for certain mental health disorders is the same as for other medical conditions.	\$10 co-pay per visit for up to 24 visits per year. As required by law, coverage for certain mental health disorders is the same as for other medical conditions.	Authorized: \$10 co-pay per visit for up to 24 visits per year * Unauthorized: Subject to deductible & coinsurance
Outpatient Drug and alcohol rehab	Unlimited outpatient visits: \$5 co-pay per visit	Unlimited outpatient visits: \$5 co-pay per visit	Covered up to 20 visits or \$500 in benefit value whichever is greater, \$10 co-pay for visits 1-8, visits after 8 are \$25 co-pay for ind and \$10 co-pay for group therapy	\$10 co-pay per visit up to \$500 per year	\$10 co-pay per visit up to \$500 per year

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<i>Routine Physicals</i>	\$5 co-pay	\$5 co-pay	\$10 co-pay	\$10 co-pay	Authorized: \$10 co-pay Unauthorized: Covered at 80% after applicable deductible
<i>Routine Eye Exams</i>	\$5 co-pay (one every 12 months)	\$5 co-pay (one every 12 months)	\$10 co-pay (one per calendar year)	\$10 co-pay (one per calendar year)	Authorized: \$10 co-pay Unauthorized: Covered at 80% after applicable deductible
<i>Well-baby care</i>	\$5 co-pay	\$5 co-pay	\$10 co-pay	\$10 co-pay	Authorized: \$10 co-pay Unauthorized: Covered at 80% after applicable deductible
<i>Allergy Injections</i>	Covered in full; \$5 co-pay applies if in conjunction with doctor visit	Covered in full; \$5 co-pay applies if in conjunction with doctor visit	\$5 co-pay	\$10 co-pay for office visit	Authorized: \$10 co-pay for office visit Unauthorized: 80% coverage after deductible
<i>X-ray and Lab Tests</i>	Covered in full	Covered in full	Covered in full	Covered in full	Authorized: In full Unauthorized: 80% coverage after deductible
<i>Home Health Care</i>	Covered in full	Covered in full	Covered in full	Covered in full	Authorized: In full Unauthorized: 80% coverage after deductible
<i>Hospice Care</i>	Covered in full (\$5 co-pay for office visits)	Covered in full (\$5 co-pay for office visits)	Covered in full (\$10 co-pay for office visits)	Covered in full	Authorized: In full Unauthorized: 80% coverage after deductible
<i>Durable Medical Equipment</i>	Covered at 100% up to \$1,500 per calendar year	Covered at 100% up to \$1,500 per calendar year	Covered at 100% up to \$2,500 per year	Covered at 100% up to \$2,500 per year	Authorized: Covered at 100% up to \$2,500 per year. Unauthorized: There is a combined authorized and unauthorized limit of \$2,500 per calendar year. Members are responsible for deductible and coinsurance.
<i>Dental</i>	Family dental coverage: \$10 co-pay for exam, cleaning, x-rays every 6 mos; 80% coverage for fillings. Discount on sealants (50%), crowns (25%), etc. Must use participating dentists	Family dental coverage: \$10 co-pay for exam, cleaning, x-rays every 6 mos; 80% coverage for fillings. Discount on sealants (50%), crowns (25%), etc. Must use participating dentists	Preventive dental for children under age 14 when authorized by PCP. Up to two exams per calendar yr, including cleaning, fluoride treatment and x-rays	Children under age 12: Periodic oral exam, cleaning, fluoride, bitewing x-rays: once every 6 mos. Must choose a dentist from directory	Not covered.

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INPATIENT					
<i>In Network Hospital Benefits</i>	When approved by FCHP physician, full payment at affiliated hospitals for: <ul style="list-style-type: none"> Semi-private room and board Covered hospital charges Physicians' and surgeons' fees and supplies 	When approved by FCHP physician, full payment at affiliated hospitals for: <ul style="list-style-type: none"> Semi-private room and board Covered hospital charges Physicians' and surgeons' fees and supplies 	When approved by HPHC physician, full payment at affiliated hospitals for: <ul style="list-style-type: none"> Semi-private room and board Covered hospital charges Physicians' and surgeons' fees and supplies 	When approved by Tufts physician, full payment at affiliated hospitals for: <ul style="list-style-type: none"> Semi-private room and board Covered hospital charges 	When approved by Tufts physician, full payment at affiliated hospitals for: <ul style="list-style-type: none"> Semi-private room and board Covered hospital charges
<i>Out of Network Hospital Benefits</i>	Not Covered (Except for emergency)	Not Covered (Except for emergency)	Not Covered (Except for emergency)	Not Covered (Except for emergency)	Unauthorized: 80% coverage after deductible
<i>Intensive Care</i>	Covered in full	Covered in full	Covered in full	Covered in full	Authorized: Covered in full Unauthorized: 80% coverage after deductible
<i>Skilled Nursing Facility, Chronic disease or Rehab hospital</i>	Covered in full; 100 day limit per yr. when medically necessary	Covered in full; 100 day limit per yr. when medically necessary	Covered in full; 100 day limit per yr. when medically necessary	Covered in full; 100-day limit per calendar year. When medically necessary	Authorized: covered in full 100 day limit per yr. when medically necessary Unauthorized: 80% after deductible, 100 day limit per calendar year, when medically necessary
<i>Inpatient Mental Health</i>	Covered in full in a licensed general hospital or in a psychiatric hospital	Covered in full in a licensed general hospital or in a psychiatric hospital	Covered as Follows: - Inpatient mental health services in a licensed general hospital – unlimited - Inpatient mental health services in a psychiatric hospital – up to 60 days per member per calendar year. As required by law, coverage for certain mental health disorders is the same as for other medical conditions.	Covered in full in Tufts Health Plan designated facility; limit of 60 days per calendar yr. As required by law, coverage for certain mental health disorders is the same as for other medical conditions.	Covered in full in Tufts Health Plan designated provider facility as well as in a MH Dept. of a general hospital; limit of 60 days per calendar yr. As required by law, coverage for certain mental health disorders is the same as for other medical conditions.
<i>Inpatient drug and alcohol rehab</i>	Covered in full up to 30 days per member per cal yr. Detoxification: covered in full for unlimited days	Covered in full up to 30 days per member per cal yr. Detoxification: covered in full for unlimited days	Covered in full up to 30 days per member per cal yr. Detoxification: covered in full for unlimited days	Covered in full at a Tufts Health Plan designated facility, 30 day limit per calendar year Detoxification: covered in full for unlimited days – pre-cert. required	Authorized: full coverage at a Tufts Health Plan designated facility; 30 day limit per calendar year Unauthorized: 80% after deductible; 30 day cal yr. Limit Detoxification: covered in full for unlimited days – pre-cert required

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Fitness	<i>It Fits</i> Program: Reimbursing members up to \$150 Ind / \$300 Fam for memberships at a local fitness center, in Weight Watchers®, Pilates, Yoga classes and local & school sports programs . Other discounts also available. See plan materials for details.	<i>It Fits</i> Program: Reimbursing members up to \$150 Ind / \$300 Fam for memberships at a local fitness center, in Weight Watchers®, Pilates, Yoga classes and local & school sports programs . Other discounts also available. See plan materials for details.	Fitness reimbursement up to \$150 per subscriber at a Fitness club or facility per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. Discounts also available at participating fitness centers. See plan materials for details.	Fitness reimbursement up to \$150 per subscriber at a Fitness club or facility per calendar year. Eligibility after 4 consecutive months of membership with both Tufts Health Plan and the qualifying health & fitness club. Discounts also available at participating health clubs. See plan materials for details.	Fitness reimbursement up to \$150 per subscriber at a participating Health Club facility per calendar year. Eligibility after 4 consecutive months of membership with both Tufts Health Plan and the qualifying health & fitness club. Discounts also available at participating health clubs. See plan materials for details.
PRESCRIPTION DRUGS (Rx)	<u>Retail for 30-day supply:</u> Tier 1: \$5 copay Tier 2: \$15 copay Tier 3: \$35 copay <u>Mail Order for up to a 90-day supply:</u> Tier 1: \$10 copay Tier 2: \$30 copay Tier 3: \$105 copay Emergency out of area for a 14 day supply: Tier 1: \$5 copay Tier 2: /\$15 copay Tier 3: \$35 copay	<u>Retail for 30-day supply:</u> \$5 tier-1/\$15 tier-2/\$35 tier-3 for up to a 30-day supply <u>Mail Order for up to a 90-day supply:</u> Tier 1: \$10 copay Tier 2: \$30 copay Tier 3: \$105 copay Emergency out of area for a 14 day supply: Tier 1: \$5 copay Tier 2: /\$15 copay Tier 3: \$35 copay	<u>Retail for 30-day supply:</u> Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay <u>Mail Order for a 90-day supply:</u> Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$75 copay	<u>PCS pharmacies Retail – 30 day supply:</u> Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay <u>PCS Mail Order for a 90-day supply:</u> Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$50 copay	<u>PCS pharmacies Retail – 30day supply:</u> Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay <u>PCS Mail Order for a 90-day supply:</u> Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$50 copay

* *Fallon DirectCare members now have access to Acton Medical Associates, Charles River Medical Associates and Southboro Medical Group (effective April 1, 2005). Members also still have access to Fallon Clinic providers and specialists.*

* *Fallon SelectCare members have access to Fallon Clinic providers, as well as hundreds of private practice physicians in Central, Northern, Eastern and Southeastern Massachusetts.*

** *This comparison is for illustrative purposes only and may be subject to errors and omissions.*