BERKSHIRE HEALTH GROUP
BENEFIT COMPARISON - effective 7/1/16-6/30/17

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) and applicable riders define the terms and conditions of these benefits in greater detail. Should any questions arise, the Certificate(s) and riders will govern.

	HMO	POS		PPO	
	NETWORK BLUE NE DEDUCTIBLE	BLUE CHOICE NE DEDUCTIBLE		BLUE CARE ELECT PREFERRED DEDUCTIBLE	
BENEFIT		PCP/PLAN APPROVED	SELF-REFERRED	IN-NETWORK	OUT-OF-NETWORK +
Deductible	$250 per member $500 - two members $750 per family	$250 per member $500 - two members $750 per family	$400 per member $800 per family	$250 per member $500 - two members $750 per family	$400 per member $800 per family
Out of Pocket (OOP) Maximum - includes deductible, all coinsurance and co-pays as indicated by plan, as required by the ACA	Medical - $2,000 per member $4,000 per family Prescription - $3,000 per member $6,000 per family	Medical - $2,000 per member $4,000 per family Prescription - $3,000 per member $6,000 per family	Medical - $3000 per member	Medical - $2,000 per member $4,000 per family Prescription - $3,000 per member $6,000 per family	Medical - $3000 per member
Lifetime Benefit Maximum	None	None	None	None	None
INPATIENT					
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room & board & special services)	$500 after deductible	$500 after deductible	20% coinsurance*	$500 after deductible	20% coinsurance*; Nothing (no deductible for emergency)
Physician Services	Nothing	Nothing	20% coinsurance*	Nothing	20% coinsurance*; Nothing (no deductible) accident admissions
Skilled Nursing Facility	Nothing after Deductible to 100 days per calendar year benefit maximum	Nothing after Deductible to 100 days per calendar year benefit maximum	20% coinsurance*; 100 days per calendar year benefit maximum (less any PCP/plan approved days used)	Nothing after Deductible to 100 days per calendar year benefit maximum combined with out-of-network days	20% coinsurance* to 100 days per calendar year benefit maximum combined with in-network days
Rehabilitation Hospital	Nothing after Deductible to 60 days per calendar year benefit maximum	Nothing after Deductible to 60 days per calendar year benefit maximum	20% coinsurance* to 60 days per calendar year benefit maximum (less any PCP/plan approved days used)	Nothing after Deductible to 60 days per calendar benefit maximum combined with out-of-network days	20% coinsurance* to 60 days per calendar year benefit maximum combined with in-network days

	HMO	POS		PPO	
	NETWORK BLUE NE DEDUCTIBLE	BLUE CHOICE NE DEDUCTIBLE		BLUE CARE ELECT PREFERRED DEDUCTIBLE	
BENEFIT		PCP/PLAN APPROVED	SELF-REFERRED	IN-NETWORK	OUT-OF-NETWORK +
OUTPATIENT HOSPITAL					
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident care	$100 per visit after deductible waived if admitted	$100 per visit after deductible waived if admitted	$100 per visit after deductible waived if admitted	$100 per visit after deductible waived if admitted	$100 per visit after deductible waived if admitted
Outpatient Surgery	$150 per day surgery $0 copay for outpatient colonoscopy-eff 7/1/09	$150 per day surgery $0 copay for outpatient colonoscopy-eff 7/1/09	20% coinsurance*	$150 per day surgery $0 copay for outpatient colonoscopy-eff 7/1/09	20% coinsurance*
Radiation and Chemotherapy	Nothing after deductible	Nothing after deductible	20% coinsurance*	Nothing after deductible	20% coinsurance*
Diagnostic X-ray and Lab	Nothing after deductible	Nothing after deductible	20% coinsurance*	Nothing after deductible	20% coinsurance*
MRI, Pet Scans, CT Scans	$100 per visit after deductible	$100 per visit after deductible	20% coinsurance*	$100 per visit after deductible	20% coinsurance*
Hemodialysis	Nothing after deductible	Nothing after deductible	20% coinsurance*	Nothing after deductible	20% coinsurance*
Physical Therapy	$20 copay to 60 visits per calendar year	$20 copay to 60 visits per calendar year	20% coinsurance*; 60 visits per calendar year combined with PCP approved visits	$20 per visit to 100 visits per calendar year benefit maximum cobined with out-of-network visits	20% coinsurance* to 100 visits per calendar year benefit maximum combined with in-network visits
Physician Office	$20 PCP $35 copay Specialist	$20 PCP $35 copay Specialist	20% coinsurance*	$20 PCP $35 copay Specialist	20% coinsurance*
Surgery - Office	$20 PCP $35 copay Specialist	$20 PCP $35 copay Specialist	20% coinsurance*	$20 PCP $35 copay Specialist	20% coinsurance*
Well Child Care	$0 per visit	$0 per visit	20% coinsurance*; 6 visits 1st year; 3 visits 2nd year; 1 visit per year ages 2-5; benefit is not limited to age base	$0 per visit; 10 visits 1st year; 3 visits 2nd year; 1 visit per year age 2-11; 1 visit every two years age 12-18	20% coinsurance*; 10visits 1st year; 3 visits 2nd year; 1 visit per year age 2-11; 1 visit every two years age 12-18
Mental Health Care, Substance Abuse Care	$20 per visit	$20 per visit	20% coinsurance*	$20 per visit	20% coinsurance*
Routine GYN Exam	$0 per visit	$0 per visit	20% coinsurance*	$0 per visit	20% coinsurance*
Routine Vision Exam	$0 per visit (1 visit per calendar year)	$0 per visit (1 visit per calendar year)	20% coinsurance*	$0 per visit (1 visit per calendar year)	All charges
Adult Preventative Physicals	$0 per visit	$0 per visit	20% coinsurance*	$0 per visit: 1 visit per 5 years ages 19-29; 1 visit per 3 years ages 30-39; 1 visit per 2 years ages 40-54; 1 visit per year age 55+	20% coinsurance*: 1 visit per 5 years ages 19-29; 1 visit per 3 years ages 30-39; 1 visit per 2 years ages 40-54; 1 visit per year age

	HMO	POS		PPO	
	NETWORK BLUE NE DEDUCTIBLE	BLUE CHOICE NE DEDUCTIBLE		BLUE CARE ELECT PREFERRED DEDUCTIBLE	
BENEFIT		**PCP/PLAN APPROVED**	**SELF-REFERRED**	**IN-NETWORK**	**OUT-OF-NETWORK +**
OTHER OUTPATIENT					
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Visiting Nurse/Home Health Care	Nothing after deductible	Nothing after deductible	20% coinsurance*	Nothing	20% coinsurance*
Durable Medical Equipment	After deductible, member pays 20%, plan pays 80% with no limit	After deductible, member pays 20%, plan pays 80% with no limit	After deductible, member pays 40% coinsurance per calendar year (less any PCP/plan approved	After deductible, member pays 20%, plan pays 80% with no limit	After deductible, member pays 40% coinsurance per calendar year
Ambulance	Nothing after deductible	Nothing after deductible	Nothing	Nothing after deductible	Nothing for accident or emergency; 20% coinsurance* other
Routine Pediatric Dental (through	Nothing	Nothing	All charges	All charges	All charges
Chiropractor Visits	$20 per visits up to 12 visits per year	$20 per visits up to 12 visits per year	All charges	$20 per visit up to 12 visits per calendar year combined with out-of-	20% coinsurance*
Prescription Drugs	$10 generic; $25 brand; $50 non-preferred brand to 30-day supply retail pharmacy or $20/$50/$110 90-day mail service supply	$10 generic; $25 brand; $50 non-preferred brand to 30-day supply retail pharmacy or $20/$50/$110 90-day mail service supply	Same as PCP/plan approved retail pharmacies outside of Massachusetts	$10 generic; $25 brand; $50 non-preferred brand to 30-day supply retail pharmacy or $20/$50/$110 90-day mail service supply	Same as In-Network at approved retail pharmacies outside of Massachusetts
WELLNESS PARTICIPATION PROGRAMS					
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
WeightWatchers®	Up to $150 toward fees paid for a qualified *Weight Watchers®* (Weight Watchers® Traditional or Weight Watchers® at Work programs only) or hospital-based weight loss program	Up to $150 toward fees paid for a qualified *Weight Watchers®* (Weight Watchers® Traditional or Weight Watchers® at Work programs only) or hospital-based weight loss program	n/a	Up to $150 toward fees paid for a qualified *Weight Watchers®* (Weight Watchers® Traditional or Weight Watchers® at Work programs only) or hospital-based weight loss program	n/a
Fitness Program	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan details.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan details.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan details.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan details.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan details.

+ You may be billed by the provider for the charges above the allowed amount
***After deductible**
Dependent Eligibility - Adult children covered up to the last day of the month of their 26th birthday