# 2017 Harvard Pilgrim Health Care
# Summary Plan Comparison

| Covered Services | Best Buy Optional "HMO" & Best Buy Optional Focus "HMO" | | Best Buy Basic Plan "HMO" & Best Buy Basic Focus "HMO" |
|---|---|---|---|
| Individual Deductible | $500 Per Calendar Year | | $1,500 Per Calendar Year |
| Family Deductible | $1,000 Per Calendar Year | | $3,000 Per Calendar Year |
| Individual Out-of-Pocket Maximum | $2,000 (Includes copays & deductible except prescriptions) | | $3,000 (Includes copays & deductible except prescriptions) |
| Family Out-of-Pocket Maximum | $4,000 (Includes copays & deductible except prescriptions) | | $6,000 (Includes copays & deductible except prescriptions) |
| Plan Coinsurance | 100% | | 100% |
| Lifetime Maximum | Unlimited | | Unlimited |
| **Preventative Office Visits**<br>Routine Physical Exams<br>Well Child Care/Immunizations<br>Routine GYN | No copay | | No copay |
| **Non-Preventative Office Visits** | $20 Copay Per Visit | | $20 Copay Per Visit |
| **Specialist Office Visits** | $20 Copay Per Visit | | $20 Copay Per Visit |
| **Routine Vision Exams** | $20 Copay Per Visit | | $20 Copay Per Visit |
| **Outpatient Diagnostic Services**<br>Diagnostic, Laboratory & X-Ray | 100% After Deductible | | 100% After Deductible |
| **Outpatient Diagnostic Services**<br>CT Scans, MRI, PET Scans | 100% After Deductible | | 100% After Deductible |
| **Outpatient Surgery**<br>Ambulatory Facility, Hospital Outpatient Dept. or Surgical Day Care Unit | 100% After Deductible | | 100% After Deductible |
| **Outpatient Rehabilitation**<br>Physical Therapy<br>Occupational Therapy | $0 after Deductible (60 Consecutive Days Per Condition) | | $0 after Deductible (60 Consecutive Days Per Condition) |
| **Speech Therapy**<br>(no maximum) | $0 After Deductible | | $0 After Deductible |
| **Chiropractic Services** | $20 Copay Per Visit<br>(12 visits Per Plan Year) | | None |
| **Inpatient Hospital Care**<br>Room & Board<br>Maternity Services | 100% After Deductible | | 100% After Deductible |
| **Emergency Care**<br>Hospital Emergency Room Care<br>(Copay waived if admitted) | $100 Copay Per Visit After Deductible | | $100 Copay Per Visit After Deductible |
| **Retail Pharmacy**<br>**(30 day supply)** Tier 1<br>Tier 2<br>Tier 3<br>Tier 4 | <br>$15 Copay<br>$40 Copay<br>$75 Copay<br>20% of cost up to $250 per month | | <br>$15 Copay<br>$40 Copay<br>$75 Copay<br>20% of cost up to $750 per month |
| **Mail Order Drugs**<br>**(90 day supply)** Tier 1<br>Tier 2<br>Tier 3<br>Tier 4 | <br>$30 Copay<br>$80 Copay<br>$225 Copay<br>20% of cost up to $250 per month | | <br>$30 Copay<br>$80 Copay<br>$225 Copay<br>20% of cost up to $750 per month |

Please refer to the Harvard Pilgrim medical benefits summaries for a detailed description of coverages, limitations, and exclusions. Available in Human Resources.