WEST SUBURBAN HEALTH GROUP

Effective 07-01-2016

HEALTH PLAN COMPARISON CHART July 1, 2016

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	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD		TUFTS HEALTH PLAN		FALLON COMMUNITY HEALTH PLAN	
	PPO									
	IN-NETWORK	OUT-OF-NETWORK	HMO RATE SAVER	CHOICENET BENCHMARK PLAN	NETWORK BLUE NE OPTIONS TIERED NETWORK HMO RATE SAVER	BENCHMARK PLAN	EPO RATE SAVER (Navigator)	BENCHMARK PLAN	EPO RATE SAVER	BENCHMARK PLAN
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None	None	None	None	None	None	None
Deductible - (Benchmark Plans only) applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - *See plan document for full details*	None	IND $100 / FAM $200 per calendar year	None	**IND $300/ FAM $900**	None	**IND $300/ FAM $900**	None	**IND $300/ FAM $900**	None	**IND $300/ FAM $900**
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year. Effective July 1, 2015, out-of-pocket maximums for prescription copays have been added as required by ACA (in-network only).	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	Not required per the ACA	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical** - $2,000 per member $4,000 per family per calendar year **Prescription**- $2,000 per member $4,000 per family per calendar year see plan for details	**Medical & Prescription Combined -** $1,000 Individual $2,000 Family per plan year	**Medical & Prescription Combined -** $2,000 Individual $4,000 Family per plan year

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	IN-NETWORK	OUT-OF-NETWORK								
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Family Covered	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Any PCP in network	No selection required	Member must select	Member must select	Member must select	Member must select	No selection required	No selection required	Member must select	Member must select
Specialist Referrals	Any HPHC Specialist	Any licensed specialist	PCP must refer	PCP must refer	PCP must refer	PCP must refer	No referral required	No referral required	PCP must refer	PCP must refer
Providers of Service	**HARVARD PILGRIM** providers - Members also have access to a wide range of participating providers through the Private Health Care Systems network while outside of MA, NH and ME	Any licensed provider; any hospital	**HARVARD PILGRIM** providers except in emergencies	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies Hospital Tiers: Tier 1: Enhanced Tier 2: Standard Tier 3: Basic	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 40,000 providers and 60 hospitals ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals. The network has more	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 40,000 providers and 60 hospitals ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals. The network has more
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions

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	IN-NETWORK	OUT-OF-NETWORK								
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
INPATIENT										
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Nothing	20% coinsurance after deductible	$250 copay	Deductible applies then: **Tier 1 : $250** **Tier 2 :$500** **Tier 3 : $1500** per/Admit NOTE-Mental Health/Substance Abuse **copay $250**	Enhanced: $250 copay Standard: $500 copay Basic: $500 copay Out-of-state copay: $250 NOTE-Mental Health/Substance Abuse copay $250	**Deductible , then Tier 1: $500 copay Tier 2: 1500 copay**	Semi-private room & board & ancillary services Tier 1: $150 copay Tier 2: $250 copay NOTE-Mental Health/Substance Abuse copay $150	Semi-private room & board & ancillary services **Tier 1: $500 copay, then deductible applies Tier 2: $1500 copay, then deductible applies NOTE-Mental Health/Substance Abuse copay $500**	$250 copay per admission ($1,000 out-of-pocket maximum) No co-pay or deductible for Mental Hospital/Substance Abuse Facility	**$500 copay** per admission, then deductible No co-pay or deductible for Mental Hospital/Substance Abuse Facility
Physician Services	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing (Hospital copay applies)	Nothing	Nothing	Nothing	Nothing	Nothing, after deductible
Skilled Nursing Facility	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year	$250 copayment for each admission, up to 100 days per year	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Nothing up to 100 days per year	Deductible, then covered in full	Covered in full up to 100 days per plan year	Covered in Full after Deductible, up to 100 days per plan year	$250 copayment for each admission, up to 100 days per year	**$500** copay per admission, then deductible Max of 100 days per year.
Newborn Well Baby Care (Inpatient)	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
OUTPATIENT										
Emergency Room Visits for Emergency or Accident Care	$40 copay, waived if admitted	$40 copay, waived if admitted	$75 copay (Inpatient copay applies if admitted) in Service Area	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	$75 copay (Inpatient copay applies if admitted)	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	$75 copay (Inpatient copay applies if admitted)	$100 copay, then deductible applies (Inpatient copay applies if admitted)	$75 copay (waived if admitted then Inpatient copay applies)	$100 copay, then deductible applies (waived if admitted, then Inpatient copay applies)

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	IN-NETWORK	OUT-OF-NETWORK								
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Care in Doctor's Office	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Outpatient Surgery in a Day Surgery facility or Hospital	Nothing	20% coinsurance after deductible	$125 copay per outpatient surgery	Deductible applies, then **$250 copay** per visit	Enhanced: $150 copay Standard: $250 copay Basic: $250 copay Out-of-State copay $150	Deductible applies, then **$250 copay** per visit	$125 copay per outpatient surgery	**$250 copay** per outpatient surgery, then deductible	$125 copay per outpatient surgery	**$250 copay** per outpatient surgery, then deductible
CT, MRI and Pet Scans	Nothing	20% coinsurance after deductible	Nothing	Deductible applies, then $100 Copay per procedure	General Hospitals: Enhanced: $75 copay Standard: $150 copay Basic: $150 Other Providers: $75 copay	Deductible, then $100 copay (scheduled outpatient)	$75 copay *Copay will not be charged when a member has a cancer diagnosis	$100 copay, then Deductible	Nothing	$100 copay, then deducutible
Hemodialysis	Nothing	20% coinsurance after deductible	Nothing	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient Services	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full
Physical Therapy	$5 copay per visit	20% coinsurance after deductible	$20 copay (short-term); up to 90 consecutive days per condition	Copay: $20 per visit - Limited to 30 visits per PlanYear	$45 copay; up to 60 visits per calendar year	$20 copay; up to 60 visits per calendar year	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year	$20 copay. PT / OT Max limit up to 60 visits per calendar year	$20 copay. PT / OT Max limit up to 60 visits per calendar year
Office Visits Primary Care Physician	$5 copay per visit	Not covered	$20 copay per visit	$20 copay per visit	Enhanced: $15 copay Standard: $25 copay Basic $45 copay Out-of-state copay $15	$20 copay	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing

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	IN-NETWORK	OUT-OF-NETWORK								
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Medical Care/Mental Health Care/Substance Abuse Care *(Mental Health copays excluded from OOP max)*	$5 copay per visit	20% coinsurance after deductible	$20 copay per visit	$20 copay per visit	Enhanced: $15 copay Standard: $25 copay Basic: $45 copay Out-of-state copay: $15 NOTE: Mental Health Care copay $15	$20 per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
Office Visits Specialist	$5 copay per visit	20% coinsurance after deductible	$35 copay per visit	**Tier 1 : $30 copay per visit Tier 2: $60 copay per visit Tier 3: $90 copay per visit**	$45 copay per visit	**$60 copay per visit**	$35 copay per visit	**$60 copay** per visit	$35 copay per visit	**$60 copay** per visit
OB/GYN	$5 copay per visit	20% coinsurance after deductible	$20 copay per visit	$20 copay per visit	$45 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full
Routine Vision Exam	$5 copay per visit; one visit per calendar year. $0 copay for children under 5 years of age Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers	$20 copay per visit; one visit per calendar year. $0 copay for children under 5 years of age	$20 copay per visit; one exam every 2 plan years $0 copay for children under 5 years of age	$0 copay; one visit every 24 months	$0 copay; one visit every 12 months	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers	$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers
Pre-Admission Testing -	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full

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	IN-NETWORK	OUT-OF-NETWORK								
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Maternity Care visits	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing	Nothing	Nothing for prenatal and postnatal outpatient care	Nothing for prenatal and postnatal outpatient care	Prenatal: $20 copay first visit only; Post natal: $20 copay per visit	Prenatal: $20 copay first visit only; Post // $20 copay per visit
Dental Services	**Children under age 14 -** Covered in full for preventative care. **All members** - $5 copay for extraction of impacted teeth and initial emergency treatment.	**Children under age 14 -** 20% coinsurance after deductible for preventative care. **All members** - 20% coinsurance after deductible for extraction of impacted teeth and initial emergency treatment.	**Children under age 12** - Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	Preventative dental for children up to age 13 - Tier 1 Copayment per visit up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	No coverage	**Children under age 12**: Preventive dental up to two exams per cal. yr., incl. Cleaning, fluoride treatment and x-rays. **All members**: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed.	**Children under age 12**; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist.Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY	**Children under age 12**; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY	**Family dental coverage:** $10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.	**Family dental coverage:** $10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.
OTHER FEATURES										
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	20% coinsurance after deductible	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary

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	IN-NETWORK	OUT-OF-NETWORK								
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Home Health Care	Nothing	20% coinsurance after deductible	Nothing	Member cost sharing depends on types of services provided and tier placement of provider rendering dervices, as listed in the Schedule of Benefits. For example, for services provided by a physician, see "physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full
Hospice Care	Nothing	20% coinsurance after deductible	Nothing	Same as Home Health Care	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full
Durable Medical Equipment	20% of equipment cost to HPHC not to exceed a member's expense of $1000,	Deductible, then 20% of equipment cost to HPHC not to exceed a member's expense of $1000	20% of HPHC cost	Deductible, then covered in full	20% coinsurance Prosthetics covered in full	Deductible, then 20% coinsurance Deductible, then 20% coinsurance	80% Covered	Deductible, then covered in full	Nothing 20% coinsurance for prosthetic limbs which replace, in whole or in part, an arm or leg.	Deductible, then covered in full 20% coinsurance after the deductlbe for prosthetic limbs which replace, in whole or in part, an arm or leg.
Ambulance	Nothing, when medically necessary	Nothing, when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Deductible then covered in full	Nothing when medically necessary	Deductible then covered in full	Nothing when medically necessary	Covered in full when medically necessary
Radiation Therapy	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full

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	IN-NETWORK	OUT-OF-NETWORK								
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Chemotherapy	Nothing	20% coinsurance after deductible	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full	Nothing	Deductible, then covered in full
Chiropractor Visits	$5 copay per visit, up to $500 per calendar year	20% coinsurance after deductible	$35 copay per visit. 12 visit maximum per calendar year	$20 copay, 20 visits per plan year	$45 copay per visit. 12 visits maximum per calendar year	$20 copay per visit. 12 visits maximum per calendar year	$20 copay per visit; up to 12 visits per calendar year	$20 copay per visit; up to 12 visits per calendar year	$20 copay per visit; up to 12 visits per calendar year.	$20 copay per visit; up to 12 visits per calendar year.
Prescription Drugs (Inpatient drugs paid in Co-pays do not count towards OOP Maximum	Retail Pharmacy: Tier 1: $5 copay Tier 2: $10 copay Tier 3: $25 copay up to a 30 day supply MedImpact Mail Order: Tier 1: $10 copay Tier 2: $20 copay Tier 3: $75 copay up to a 90 day supply	Retail Pharmacy: Tier 1: $5 copay Tier 2: $10 copay Tier 3: $25 copay up to a 30 day supply No mail order coverage except through MedImpact Mail Order	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $45.00 copay (up to a 30-day supply Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $90.00 copay	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply Mail Order: (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail Pharmacy: Tier 1: $15.00 copay Tier 2: $30.00 copay Tier 3: $50.00 copay (up to a 30-day supply Mail Order: (90 day supply) Tier 1: $30.00 copay Tier 2: $60.00 copay Tier 3: $100.00 copay	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply Mail Order: (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $45.00 copay (up to a 30-day supply Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $90.00 copay	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply Mail Order: (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $45.00 copay (up to a 30-day supply Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $90.00 copay	Retail Pharmacy: Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply Mail Order: (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay

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	IN-NETWORK	OUT-OF-NETWORK								
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Fitness Benefit	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**
	Fitness reimb up to **$150** per subscriber at a Health & Fitness club 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. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club 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. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club 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. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club 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. See plan materials for details.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan materials for details.	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details.	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.
	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.	The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.

* **Fallon DirectCare** - Members now have access to Acton Medical Associates, Charles River Medical Associates and Southboro Medical Group, Fallon Clinic, Highland Healthcare Associates IPA, Lahey Clinic, Lawrence General IPA, Lowell General PHO, Mount Auburn Cambridge IPA, and Northeast PHO.

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