Clark University Health Plans Comparison and Rates Chart
Rates Effective January 1, 2021

	HPHC FOCUS NETWORK℠	HPHC HMO	HPHC Best Buy HMO	HARVARD PILGRIM PPO
	Contact Member Services 1-888-333-4742 or visit www.harvardpilgrim.org			
	Limited provider network. Access to more than 16,000 Providers and 57 hospitals within MA.	Access to over 28,000 Providers and 135 hospitals within MA, NH, ME, and RI		Harvard Pilgrim's PPO product includes a national network of participating physicians credentialed by Private Healthcare Systems (PHCS).
	Must choose an in network Primary Care Physician (PCP) and PCP referrals are required (e.g. Specialists, etc.)			PCP not required
			Deductibles apply	Deductibles apply for out-of-network services
New Rates Effective January 1 to December 31, 2021				
Contributions	**Individual** / **Family**	**Individual** / **Family**	**Individual** / **Family**	**Individual** / **Family**
Total Monthly Premium	$ 704.20 / $ 1,831.80	$ 913.76 / $ 2,380.32	$ 786.80 / $ 2,047.80	$ 1,082.00 / $ 2,808.82
Clark's Monthly Contribution	$ 595.00 / $ 1,371.00	$ 595.00 / $ 1,371.00	$ 595.00 / $ 1,371.00	$ 595.00 / $ 1,371.00
Employee Monthly Contribution	$ 109.20 / $ 460.80	$ 318.76 / $ 1,009.32	$ 191.80 / $ 676.80	$ 487.00 / $ 1,437.82
Bi-Weekly Deduction (24 Pays)	$ 54.60 / $ 230.40	$ 159.38 / $ 504.66	$ 95.90 / $ 338.40	$ 243.50 / $ 718.91
Prior plan year rates effective January 1 to December 31, 2020				
Contributions	**Individual** / **Family**	**Individual** / **Family**	**Individual** / **Family**	**Individual** / **Family**
Bi-Weekly Deduction (24 Pays)	$ 50.57 / $ 213.50	$ 147.25 / $ 466.82	$ 88.70 / $ 313.14	$ 224.25 / $ 664.83
Out-of-pocket costs				
Calendar Year Deductible	none	none	$1000 Individual / $2000 Family	none / $500 Individual / $1000 Family
In-network Out-of-pocket maximum	$2500 Ind/$5000 Family		$5000 Individual / $10,000 Family	$2500 Ind/$5000 Family
Co-Insurance	n/a			20% after deductible
Outpatient Care				
Preventive Care Office Visits (annual exams with PCP or gynecologist and well-child visits)	Covered in full			20% Coinsurance after deductible
PCP Office Visits	$25 per visit			
Specialist Office Visits	$25 per visit			
Emergency Room Visits	$100 per visit (waived if admitted)		$100 per visit (not subject to deductible) waived if admitted	$100 per visit (waived if admitted)
Urgent Care Hospital/Clinic	$25 per visit			
Mental health and substance abuse treatment	$25 per visit			
Acupuncture	$25 per visit; maximum of 20			
Chiropractic Care (manual manipulation of the spine)	$25 per visit; maximum of 20			
Short term rehabilitation therapy	$25 co-pay (up to 30 PT visits and 30 OT visits per CY)		Subject to deductible; then covered in full (up to 30 PT visits and 30 OT visits per CY)	$25 co-pay (up to 30 PT visits an 30 OT visits per CY)
Allergy Injections	$5 per visit		$5 per visit (not subject to deductible)	$5 per visit
Speech, hearing and language disorder treatment - speech therapy	$25 per visit		Covered in full; after deductible	$25 per visit
Preventive Dental Care (children up to age 13)	Covered in full (2 visits per member per year)			
Vision Tests	$25 copayment (once per year)			
Diagnostic X-rays, lab tests, and other tests	Covered in full		Covered in full; after deductible	Covered in full
Imaging: MRI,CAT, PET, etc.	$75 co-pay per visit (only charged 2x per year maximum)			
Home health care and hospice services	Subject to $500 per admission copayment or $250 per visit day surgery		Covered in full; after deductible	Subject to $500 / admission co-pay or $250 / visit day surgery
Oxygen and equipment for its administration	Covered in full		Covered in full; after deductible	Covered in full
Durable medical equipment / Prosthetics	20% cost sharing			
Surgery and related anestesia	Subject to $500 per admission copayment or $250 per visit day surgery		Covered in full; after deductible	Subject to $500 / admission co-pay or $250 / visit day surgery
Inpatient Care (including maternity care)				
Hospital Care / **Rehabilitation hospital care (60 days per calendar year)** / **Skilled nursing facility care (100 dyas per calendar yeear)**	Subject to $500 per admission copayment or $250 per visit day surgery		Covered in full; after deductible	Subject to $500 per admission copayment or $250 per visit day surgery / 20% Coinsurance after deductible
Prescriptions				

Effective 1/1/2020 enhancements to the Rx plan through OPTUMRx® will be implemented moving the OPTUMRx® exclusive specialty prescription program to Briova.	**Retail**	**Tiers**	**Mail Order (90 day supply)**
	$5	Tier 1- Low cost generics	$10
	$20	Tier 2- High cost generics	$40
	$30	Tier 3- Preferred brand name	$60
	$50	Tier 4 - Non-preferred brands	$150
	$100	Tier 5 - Specialty drugs	$300

Blue Cross Blue Shield www.bluecrossma.com 1-800-358-2227

Plan year 2021 Premium Rates	**Individual**	**Family**	
Individual Monthly Premium	$ 48.38	$ 128.16	No Deductibles Maximum Calendar year coverage is $1,500 per person
Bi-Weekly Deduction (24 Pays)	$ 24.19	$ 64.08	