Clark University Health Plans Comparison and Rates Chart
Rates Effective January 1, 2022

	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, 2022								
Contributions	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**
Total Monthly Premium	$ 759.62	$ 1,975.74	$ 986.06	$ 2,568.44	$ 848.78	$ 2,209.10	$ 1,166.56	$ 3,031.42
Clark's Monthly Contribution	$ 642.00	$ 1,479.00	$ 642.00	$ 1,479.00	$ 642.00	$ 1,479.00	$ 642.00	$ 1,479.00
Employee Monthly Contribution	$ 117.62	$ 496.74	$ 344.06	$ 1,089.44	$ 206.78	$ 730.10	$ 524.56	$ 1,552.42
Bi-Weekly Deduction (24 Pays)	$ 58.81	$ 248.37	$ 172.03	$ 544.72	$ 103.39	$ 365.05	$ 262.28	$ 776.21
Prrior Plan year rates Effective January 1 to December 31, 2021								
Contributions	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**
Bi-Weekly Deduction (24 Pays)	$ 54.60	$ 230.40	$ 159.38	$ 504.66	$ 95.90	$ 338.40	$ 243.50	$ 718.91

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	$150 per visit (waived if admitted)		$150 per visit (not subject to deductible) waived if admitted	$150 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 30				
Chiropractic Care (manual manipulation of the spine)	$25 per visit; maximum of 30				
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	
Fitness Center Reimbursement	$150 for up to two (2) covered members (maximum $300)				
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

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

Plan year 2022 Premium Rates	**Individual**	**Family**	
Individual Monthly Premium	$ 47.42	$ 125.60	No Deductibles Maximum Calendar year coverage is $1,500 per person
Bi-Weekly Deduction (24 Pays)	$ 23.71	$ 62.80	