MNHG Health Plan Benefit Comparison

Lower Deductible HMO Plans - July 1, 2022 to June 30, 2023

Effective 07-01-2022

changes and/or clarifications in red font	TUFTS HEALTH PLAN	BLUE CROSS BLUE SHIELD ^see footnote	HARVARD PILGRIM HEALTH CARE
		Network Blue New England	
BENEFIT	**Advantage EPO**	**Network Blue Select (Limited Network)**	**HMO**
Deductible - *applies to: In-patient Admissions; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to routine office visits or pharmacy. Per plan year (July 1 to June 30) -* ***See plan document for full details***	$300 per member not to exceed $900 per family	$300 per member not to exceed $900 per family	$300 per member not to exceed $900 per
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. NOTE: prescription out-of-pocket maximums added effective June 1, 2015 as required by ACA (in-network only).*	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical & Prescription Combined** $2,000 per member $4,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family
Lifetime Benefit Maximum	None	None	None
INPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - Deductible Applies	$500 copay per admission	deductible then $500 copay per admission, substance abuse and mental health inpatient visits are covered in full	$500 copay per admission then deductible for medical inpatient; substance abuse and mental health inpatient visits are covered in full
Physician Services	Nothing	Nothing	Nothing
Skilled Nursing Facility - Deductible Applies	No copay to 100 days per plan year benefit maximum, when medically necessary	**CIF after deductible**, up to 100 days per plan year at a semi-private rate for each benefit	Deductible, then $500 copay, up to 100 days per plan year at a semi-private rate for each benefit
Rehabilitation Hospital - Deductible Applies	No copay to 100 days per plan year benefit maximum, when medically necessary	**CIF after deductible**, up to 100 days per plan year at a semi-private rate for each benefit	Deductible, then $500 copay, up to 60 days per plan year at a semi-private rate for each benefit

MNHG Health Plan Benefit Comparison

Lower Deductible HMO Plans - July 1, 2022 to June 30, 2023

Effective 07-01-2022

changes and/or clarifications in red font	TUFTS HEALTH PLAN	BLUE CROSS BLUE SHIELD ^see footnote	HARVARD PILGRIM HEALTH CARE
		Network Blue New England	
BENEFIT	Advantage EPO	Network Blue Select (Limited Network)	HMO
OUTPATIENT	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care - Deductible Applies	$100 copay (waived if admitted)	$100 copay, (waived if admitted)	$100 copay, then deductible, (waived if admitted)
Emergency Room Visits for Medical Care - Deductible Applies	$100 copay, waived if admitted	$100 copay, waived if admitted	$100 copay, then deductible, waived if admitted
Surgery - Deductible Applies	$250 copay	$250 copay	$250 copay
Radiation and Chemotherapy Deductible Applies	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full
Diagnostic X-ray and Lab - Deductible Applies	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay	$0 copay
High Cost Radiology (MRI, CT & PET) - Deductible Applies	$100 copay	$100 copay, then deductible	Deductible, then $100 copay
Hemodialysis - Deductible Applies	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)
Physical Therapy	Covered in full after deductible. 30 visit limit per plan year.	$20 co-pay up to 60 visits per benefit policy	$20 co-pay up to 30 visits per plan year
Visiting Nurse Home Health Care - Deductible applies where noted	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)
Dental Benefit	No coverage	No coverage	No coverage

MNHG Health Plan Benefit Comparison

Lower Deductible HMO Plans - July 1, 2022 to June 30, 2023

Effective 07-01-2022

changes and/or clarifications in red font	TUFTS HEALTH PLAN	BLUE CROSS BLUE SHIELD ^see footnote	HARVARD PILGRIM HEALTH CARE
BENEFIT	Advantage EPO	Network Blue New England Network Blue Select (Limited Network)	HMO
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**
Surgery - NO Deductible	Surgery in a Physician's office is CIF once the deductible has been met	$20 PCP copay and $45 Specialist copay	Copay Level 1 provider : $20 per visit Copay Level 2 provider : $45 per visit
Adult Preventative Exam *(includes preventative lab tests)*	$0 copay	$0 copay	$0 copay
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	$20 copay	$20 copay	$20 copay
Well Child Care *(includes preventative lab tests)*	$0 copay	$0 copay (including routine physical exams, immunizations, annual eye exam, school, camp, sports)	$0 copay (including routine physical exams, immunizations, school, camp, sports)
Routine GYN Exam *(one per calendar year, includes preventative lab tests)*	$0 copay	$0 copay	$0 copay
Routine Mammogram	$0 copay	$0 copay	$0 copay
Routine Vision Exam	$20 copay (once per plan year)	Covered in full (once every 12 months)	Limited 1 per Plan Year - No Charge
Routine Maternity Care Office Visits	Prenatal and Postpartum care covered in full	No charge for routine	No charge for routine
Specialist Office Visit	$45 copay	$45 copay	$45 copay
OTHER OUTPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**
Durable Medical Equipment - Deductible applies where noted	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)
Ambulance	$0 copay	$0 copay	$0 copay
Routine Pediatric Dental	Children under age 12: Periodic oral exam, cleaning, fluoride, bitewing x-rays; once every 6 mos. Must choose a dentist from directory	Covered in full: Preventive care for children under age 12 one visit each six months	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & fluoride treatment.
Chiropractor Visits - Deductible applies where noted	Covered in full after deductible. 12 visit limit per plan year	$20 copay, maximum of 12 visits per plan year	No coverage

MNHG Health Plan Benefit Comparison

Lower Deductible HMO Plans - July 1, 2022 to June 30, 2023

Effective 07-01-2022

changes and/or clarifications in red font	TUFTS HEALTH PLAN	BLUE CROSS BLUE SHIELD ^see footnote	HARVARD PILGRIM HEALTH CARE
BENEFIT	**Advantage EPO**	**Network Blue New England** **Network Blue Select (Limited Network)**	**HMO**
Prescription Drugs	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay
Prescription Drugs (cont)	Mail Order: (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Mail Order: (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Mail Order: (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay
Fitness & Wellness Benefits	**Fitness reimbursement up to $150** per subscriber at a Fitness club or facility per plan year. Eligibility after 4 consecutive months of membership with both THP and the qualifying health and fitness club. The reimbursement criteria will be expanded to include organized group exercise classes. Classes must be provided within a studio or fitness facility. This expansion excludes dance classes, and any classes received in a home or resident setting. Discounts also available at participating health clubs. See plan	**Up to $300** reimbursement toward in-person/virtual health club membership and classes and fitness equipment. See plan materials for details. Enroll in a qualified weight loss program and receive **up to $150** per calendar year toward your program fees.	**Up to $150** reimbursement per calendar year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.

***After Deductible**

^BCBS Network Blue New England (Full-Network) service area includes all cities and towns in Massachusetts, Rhode Island, Vermont, Connecticut, Maine, and New Hampshire. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area.

^BCBS Network Blue Select (Limited-Network) is a limited provider network with great value. It features a smaller and very attractive provider network with recognized Massachusetts doctors and hospitals, as well as specialty pediatric, eye, ear and cancer hospitals, keeping employer and employee affordability in mind. Hospitals are aligned with provider networks to improve network use.

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