MINUTEMAN NASHOBA HEALTH GROUP (MNHG)

IMPORTANT - PLEASE READ

The attached benefit comparison chart is a high level overview of the plans offered by MNHG.
The plan documents available to registered users on the carrier websites are the documents that describe full and complete plan details.
The carrier documents are the only documents that coverage is based on.
Should you have a question about specific coverage, you will need to contact the Member Service number on your ID card for detail or visit the carrier website.

MNHG Health Plan Benefit Comparison

June 1, 2018 to May 31, 2019

Effective 06-01-2018

changes and/or clarifications in red font

	TUFTS HEALTH PLAN			FALLON COMMUNITY HEALTH PLAN	HARVARD PILGRIM HEALTH CARE		
		ADVANTAGE PPO		SELECTCARE & DIRECTCARE		PPO	
BENEFIT	**ADVANTAGE HMO**	**In-Network**	**Out-of-Network**	**HMO PLANS^***see footnote*	**HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
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 (June 1 to ,May 31) -* ***See plan document for full details***	$300 per member not to exceed $900 per family	$300 per member not to exceed $900 per	$400 per member $800 per family	$300 per member not to exceed $900 per family	$300 per member not to exceed $900 per	$300 per member not to exceed $900 per	$400 per member $800 per family
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:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical only:** $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	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical only:** $3,000 per member
Lifetime Benefit Maximum	None	None	None	None	None	None	None
INPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**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	$500 copay per admission	20% coinsurance*	$500 copay per admission, **then** deductible for medical inpatient; 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	$500 copay per admission	20% coinsurance*
Physician Services	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Skilled Nursing Facility - Deductible Applies	No copay to 100 days per plan year benefit maximum, when medically necessary	No copay to 100 days per plan year benefit maximum, when medically necessary	20% coinsurance* up 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	CIF after deductible, up to 100 days per plan year at a semi-private rate for each benefit	Limit to 100 days per Plan Year - $500 copay per admission	20% coinsurance*
Rehabilitation Hospital - Deductible Applies	No copay to 100 days per plan year benefit maximum, when medically necessary	No copay to 100 days per plan year benefit maximum, when medically necessary	20% coinsurance* up 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	CIF after deductible, up to 100 days per plan year at a semi-private rate for each benefit	Limit to 60 days per Plan Year - $500 copay per admission	20% coinsurance*

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		ADVANTAGE PPO		SELECTCARE & DIRECTCARE		PPO	
BENEFIT	**ADVANTAGE HMO**	**In-Network**	**Out-of-Network**	**HMO PLANS^***see footnote***	**HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**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 (waived if admitted)	$100 copay, (waived if admitted)	$100 copay, then deductible, (waived if admitted)	$100 copay, (waived if admitted)	$100 copay, (waived if admitted)
Emergency Room Visits for Medical Care - Deductible Applies	$100 copay, waived if admitted	$100 copay, waived if admitted	$100 copay, waived if admitted	$100 copay, waived if admitted	$100 copay, then deductible, waived if admitted	$100 copay, waived if admitted	$100 copay, waived if admitted
Surgery - Deductible Applies	$250 copay	$250 copay	20% coinsurance*	$250 copay	$250 copay	$250 copay	20% coinsurance*
Radiation and Chemotherapy Deductible Applies	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*	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)	20% coinsurance*
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)	20% coinsurance*	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)	20% coinsurance*
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
High Cost Radiology (MRI, CT & PET) - Deductible Applies	$100 co-pay	$100 co-pay	20% coinsurance*	$100 co-pay	$100 co-pay, then deductible	$100 co-pay	20% coinsurance*
Hemodialysis - Deductible Applies	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*	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)	20% coinsurance*
Physical Therapy	Covered in full after deductible. 30 visit limit per plan year.	Covered in full after deductible. 30 visit limit per plan year.	20% Coinsurance * 30 visit limit per plan year.	$20 co-pay up to 60 visits per benefit policy	$20 co-pay up to 60 visits per plan year	30 visits per Plan Year - $20 copay per visit	20% coinsurance* 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)	20% coinsurance*	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)	20% coinsurance*
Dental Benefit	No coverage	No coverage	No 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.	No coverage	No coverage	No coverage

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BENEFIT	**ADVANTAGE HMO**	**In-Network**	**Out-of-Network**	**HMO PLANS^*see footnote***	**HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Surgery - NO Deductible	$20 PCP copay and $45 Specialist copay	$20 PCP copay and $45 Specialist copay	20% coinsurance*	$20 PCP copay and $45 Specialist copay	Copay Level 1 provider : $20 per visit Copay Level 2 provider : $35 per visit	Copay Level 1 provider : $20 per visit Copay Level 2 provider : $35 per visit	20% coinsurance*
Adult Preventative Exam *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	$20 copay	$20 copay	20% coinsurance*	$20 copay	$20 copay	$20 copay	20% coinsurance*
Well Child Care *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay (including routine physical exams, immunizations, annual eye exam, school, camp, sports)	$0 copay (including routine physical exams, immunizations, school, camp, sports)	$0 copay (including routine physical exams, immunizations, school, camp, sports)	20% coinsurance*
Routine GYN Exam *(one per calendar year, includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
Routine Mammogram	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay	$0 copay	20% coinsurance*
Routine Vision Exam	$20 copay (once per plan year)	$20 copay (once per plan year)	20% coinsurance* (once per plan year)	$0 copay (once every 12 months)	Limited 1 per Plan Year - No Charge	Limited 1 per Plan Year - No Charge	20% coinsurance*
Routine Maternity Care Office Visits	Prenatal and Postpartum care covered in full	Prenatal and Postpartum care covered in full	20% coinsurance	Prenatal: $20 copay first visit only; Postnatal: $20 copay per visit	$20 copay (Initial copay only)	$20 copay (Initial copay only)	20% coinsurance
Specialist Office Visit	$45 copay	$45 copay	20% coinsurance*	$45 copay	$45 copay	$45 copay	20% coinsurance*
OTHER OUTPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**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)	30% coinsurance, after deductible	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)	20% coinsurance*
Ambulance	$0 copay	$0 copay	Nothing for accident or emergency; Non Emergency Transport - 20% Coinsurance*	$0 copay	$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	Children under age 12: Periodic oral exam, cleaning, fluoride, bitewing x-rays; once every 6 mos. Must choose a dentist from directory	No 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.	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & flouride treatment.	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & flouride treatment.	All charges
Chiropractor Visits -	Covered in full after	Covered in full after	20% coinsurance after	$20 copay, maxium of 12 visits per	No coverage	No coverage	No coverage

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		ADVANTAGE PPO		SELECTCARE & DIRECTCARE		PPO	
BENEFIT	**ADVANTAGE HMO**	**In-Network**	**Out-of-Network**	**HMO PLANS^***see footnote***	**HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible applies where noted	deductible. 12 visit limit per plan year	deductible. 12 visit limit per plan year	deductible. 12 visit limit per plan year	plan year			

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BENEFIT	ADVANTAGE HMO	In-Network	Out-of-Network	HMO PLANS^*see footnote*	HMO	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay Mail Order: (90 day supply) Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay Mail Order: Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay Mail Order: Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay Mail Order: (90 day Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay Mail Order: Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay Mail Order: Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay Mail Order: 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 materials for details	**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 materials for details	**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 materials for details	**SELECTCARE - $200 - Individual / $400 Family** - Reimbursement for Gyms, School and Town Sports to name a few. **DIRECTCARE - $250 - Individual / $500 Family** - Reimbursement for Gyms, School and Town Sports to name a few. **WELLNESS -** The Healthy Health Plan – An online wellness program that rewards subscribers and their covered spouses for being, and becoming, healthy. Members simply visit fallonhealth.org/healthyhealthplan , fill out the health assessment, and if eligible, they will receive **up to $100**. Members that need a little help getting healthier may participate in interactive health tools, health coaching, and more. Members that are already in excellent health also have access to the same tools to assist them in staying healthy.	**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.	**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.	**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**

^FCHP SELECTCARE AND DIRECTCARE PROVIDER NETWORKS - SEE BELOW

Select Care is an expansive network that includes physician practices, community-based hospitals and medical facilities across Massachusetts and southern New Hampshire. Select Care offers greater choice at a competitive price. The Select Care service area includes all of Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties. With more than 35,000 providers, Select Care means more options and choices for you and your family.

Direct Care is a limited provider network, including premier provider groups and community hospitals offering high-quality care at an affordable premium. These providers are chosen for their medical excellence, patient access and innovation. There are more than 22,000 participating providers in the Direct Care network.
As a Direct Care member, if you ever should need a second opinion or the specialized expertise of Boston research and teaching hospitals, Fallon Direct Care offers access through our exclusive Peace of Mind ProgramTM.

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.