MNHG Health Plan Benefit Comparison

HSA-Qualified Health Plans - July 1, 2022 to June 30, 2023

Effective 07-01-2022

changes and/or clarifications in red font

BENEFIT	TUFTS HEALTH PLAN ADVANTAGE HMO	BLUE CROSS BLUE SHIELD Access Blue NE Saver HMO PLAN^*see footnote*	HARVARD PILGRIM HEALTH CARE HMO
Deductible applies to all services (except preventative services described under the ACA) until it is satisfied. After that, only prescription co-pays will apply. Per plan year (June 1 to ,May 31) - ***See plan document for full details***	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family
Out-of-Pocket (OOP) Maximum - *Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for the remainder of plan year.*	**Combined Medical & Prescription** $6,550 Individual $13,100 Family	**Combined Medical & Prescription** $6,550 Individual $13,100 Family	**Combined Medical & Prescription** $6,550 Individual $13,100 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	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Physician Services	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Skilled Nursing Facility - Deductible Applies	Deductible, then CIF* up to 100 days per plan year benefit maximum, when medically necessary	Deductible, then CIF* up to 100 days per plan year benefit maximum, when medically necessary	Deductible, then CIF* up to 100 days per plan year benefit maximum, when medically necessary
Rehabilitation Hospital - Deductible Applies	Deductible, then CIF* up to 100 days per plan year benefit maximum, when medically necessary	Deductible, then CIF* up to 100 days per plan year benefit maximum, when medically necessary	Deductible, then CIF* up to 60 days per plan year benefit maximum, when medically necessary
OUTPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**
Emergency Room Visits for Emergency or Accident Care - Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Emergency Room Visits for Medical Care - Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Surgery - Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Radiation and Chemotherapy Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Diagnostic X-ray and Lab - Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay	$0 copay
High Cost Radiology (MRI, CT & PET) - Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*

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OUTPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**
Hemodialysis - Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Physical Therapy	Deductible, then CIF. 30 visit limit per plan year.	Deductible, then CIF. 60 visit limit per plan year.	Deductible, then CIF. 30 visit limit per plan year.
Visiting Nurse Home Health Care - Deductible applies where noted	Covered in full (after the deductible has been met)	Deductible, then CIF	Covered in full (after the deductible has been met)
Dental Benefit	No coverage	No coverage	No coverage
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**
Surgery	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Adult Preventative Exam *(includes preventative lab tests as defined by ACA)*	CIF	CIF	CIF
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Well Child Care *(includes preventative lab tests)*	CIF	$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)*	CIF	CIF	CIF
Routine Mammogram	CIF	CIF	CIF
Routine Vision Exam	CIF (one exam per plan year)	Covered in full (once every 12 months)	CIF* (one exam per year)
Routine Maternity Care Office Visits	Prenatal and Postpartum care covered in full (after the deductible has been met)	Prenatal: Covered in full ; Postnatal: Cover in full after deductible	$20 copay (Initial copay only)
Specialist Office Visit	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
OTHER OUTPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**
Durable Medical Equipment - Deductible applies where noted	Covered in full (after the deductible has been met)	Deductible, then CIF	Covered in full (after the deductible has been met)
Ambulance	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
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 : 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, & flouride treatment.
Chiropractor Visits - Deductible applies where noted	Deductible, then CIF*. 12 visit limit per plan year	Deductible, then CIF*. 12 visit limit per plan year	Deductible, then CIF*. 12 visit limit per plan year

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BENEFIT	ADVANTAGE HMO	Access Blue NE Saver HMO PLAN^*see footnote*	HMO
Prescription Drugs - Deductible, then copays apply. *See carrier lists of preventative drugs, which are not deductible applicable - member pays copays immedicately.*	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: (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: (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 materials for details	**Fitness Reimbursement up to $300** A program that rewards participation in qualified firness programs borh in-person and virtual or equipment. (See your benefit description for details. **Weight Loss Reimbursement $150** A program that rewards participation in a qualified weight loss program. (See your benefit description for details)	**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 HMO Blue NEW ENGLAND providers in all 6 New England states except in emergencies

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.