

MNHG Health Plan Benefit Comparison
HSA-Qualified Health Plans - July 1, 2023 to June 30, 2024

Effective 07-01-2023

changes and/or clarifications in red font

	TUFTS HEALTH PLAN	BLUE CROSS BLUE SHIELD	BLUE CROSS BLUE SHIELD	HARVARD PILGRIM HEALTH CARE
	ADVANTAGE HMO SAVER	Access Blue NE Saver HMO PLAN [^] see footnote	Network Blue Select Saver HMO PLAN [^] see footnote	BEST BUY HSA HMO
BENEFIT				
<i>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 (July 1, to June 30) - See plan document for full details</i>	\$2,000 per individual \$4,000 per family	\$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	Combined Medical & Prescription \$6,550 Individual \$13,100 Family
Lifetime Benefit Maximum	None	None	None	None
INPATIENT	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	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Physician Services	Deductible, then CIF*	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	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 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	YOU PAY
Emergency Room Visits for Emergency or Accident Care - Deductible Applies	Deductible, then CIF*	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*	Deductible, then CIF*
Surgery - Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Radiation and Chemotherapy Deductible Applies	Deductible, then CIF*	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*	Deductible, then CIF*
Routine Colonoscopy (without surgery)	\$0 copay	\$0 copay	\$0 copay	\$0 copay
High Cost Radiology (MRI, CT & PET) - Deductible Applies	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*

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OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Hemodialysis - Deductible Applies	Deductible, then CIF*	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. 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	Deductible, then CIF	Covered in full (after the deductible has been met)
Dental Benefit	No coverage	No coverage	No coverage	No coverage
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
Adult Preventative Exam (includes preventative lab tests as defined by ACA)	CIF	CIF	CIF	CIF
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	Deductible, then CIF*	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, 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	CIF
Routine Mammogram	CIF	CIF	CIF	CIF
Routine Vision Exam	CIF (one exam per plan year)	Covered in full (once every 12 months)	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	Prenatal: Covered in full ; Postnatal: Cover in full after deductible	Routine outpatient prenatal and postpartum care covered in full
Specialist Office Visit	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*	Deductible, then CIF*
OTHER OUTPATIENT	YOU PAY	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	Deductible, then CIF	Covered in full (after the deductible has been met)
Ambulance	Deductible, then CIF*	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 : children under age 12 one visit each six months.	Deductible, then CIF*: 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	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	Deductible, then CIF*. 12 visit limit per plan year

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BENEFIT	ADVANTAGE HMO SAVER			BEST BUY HSA HMO
Prescription Drugs - Deductible, then copays apply. <i>See carrier lists of preventative drugs, which are not deductible applicable - member pays copays immediately.</i>	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	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 fitness programs both 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)	Fitness Reimbursement up to \$300 A program that rewards participation in qualified fitness programs both 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 per subscriber 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. Must be enrolled in HPHC at the time of reimbursement
*After Deductible				

[^]BCBS HMO BLUE NEW ENGLAND and HMO BLUE SELECT PROVIDER NETWORKS - SEE BELOW

HMO BLUE NEW ENGLAND is an expansive network of providers all six New England States. (For the Network Blue New England plan)

HMO BLUE SELECT is a limited provider network with great value. HMO BLUE SELECT 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. (For Network Blue Select)

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.