MNHG Health Plan Benefit Comparison

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	HARVARD PILGRIM HEALTH CARE		
		ADVANTAGE PPO		NWB New England & NWB Select		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 (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	$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*	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	$500 copay per admission for medical impatient	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	Deductible, then $500 copay, 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	Deductible, then $500 copay, up to 60 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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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	Covered in full	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 copay	$100 copay	20% coinsurance*	$100 copay, then deductible	Deductible, then $100 copay	$100 copay	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 30 visits per plan year	$20 copay up to 30 visits per plan year	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	No coverage	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	Surgery in a Physician's office is CIF once the deductible has been met	Surgery in a Physician's office is CIF once the deductible has been met	20% coinsurance*	$20 PCP copay and $45 Specialist copay	Copay Level 1 provider : $20 per visit Copay Level 2 provider : $45 per visit	Copay Level 1 provider : $20 per visit Copay Level 2 provider : $45 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)	Covered in full (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	No charge for routine	No charge for routine outpatient prenatal and postpartum care	No charge for routine outpatient prenatal and postpartum care	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 for accident or emergency, Deductible then 20% coinsurance for non-emergency.
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	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, & 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.	Deductible, then 20% coinsurance
Chiropractor Visits - Deductible applies where noted	Covered in full after deductible. 12 visit limit per plan year	Covered in full after deductible. 12 visit limit per plan year	20% coinsurance after deductible. 12 visit limit per plan year	$20 copay, maxium of 12 visits per plan year	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
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	**Up to $300** reimbursement toward in-person/virtual health club membership and classes and fitness equipment. See plan materials for details. Enroll in a qualifed weight loss program and receive **up to $150** per calendar year toward your program fees.	**Up to $150** per subsctiber 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.	**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.	**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. 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.