MNHG Health Plan Benefit Comparison

BCBS Lower Deductible Plan vs BCBS High Deductible Health Plan

Effective 07-01-2022

	BLUE CROSS BLUE SHIELD ^see footnote	**BLUE CROSS BLUE SHIELD ^see footnote**
BENEFIT	**Network Blue New England** **Network Blue Select (Limited Network)**	**Access Blue New England Saver**
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	$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 remainder of plan year. NOTE: prescription out-of-pocket maximums added effective June 1, 2015 as required by ACA (in-network only).*	**Medical & Prescription Combined** $2,000 per member $4,000 per family	**Medical & Prescription Combined** $6,550 Individual $13,100 Family
Lifetime Benefit Maximum	None	None
INPATIENT	**YOU PAY**	**YOU PAY**
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - Deductible Applies	deductible then $500 copay per admission, substance abuse and mental health inpatient visits are covered in full	Deductible, then CIF*
Physician Services	Nothing	Deductible, then CIF*
Skilled Nursing Facility - Deductible Applies	**CIF after deductible**, up to 100 days per plan year at a semi-private rate for each benefit	Deductible, then CIF* up to 100 days per plan year benefit maximum, when medically necessary
Rehabilitation Hospital - Deductible Applies	**CIF after deductible**, up to 100 days per plan year at a semi-private rate for each benefit	Deductible, then CIF* up to 100 days per plan year benefit maximum, when medically necessary
OUTPATIENT	**YOU PAY**	**YOU PAY**
Emergency Room Visits for Emergency or Accident Care - Deductible Applies	$100 copay, (waived if admitted)	Deductible, then CIF*
Emergency Room Visits for Medical Care - Deductible Applies	$100 copay, waived if admitted	Deductible, then CIF*
Surgery - Deductible Applies	$250 copay	Deductible, then CIF*
Radiation and Chemotherapy Deductible Applies	Covered in full (after the deductible has been met)	Deductible, then CIF*
Diagnostic X-ray and Lab - Deductible Applies	Covered in full (after the deductible has been met)	Deductible, then CIF*
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay
High Cost Radiology (MRI, CT & PET) - Deductible Applies	$100 copay, then deductible	Deductible, then CIF*

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Hemodialysis - Deductible Applies	Covered in full (after the deductible has been met)	Deductible, then CIF*
Physical Therapy	$20 co-pay up to 60 visits per benefit policy	Deductible, then CIF. 60 visit limit per plan year.
Visiting Nurse **Home Health Care - Deductible applies where noted**	Covered in full (after the deductible has been met)	Decuctible, then CIF*
Dental Benefit	No coverage	No coverage
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY
Surgery	$20 PCP copay and $45 Specialist copay - no deductible	Deductible, then CIF*
Adult Preventative Exam *(includes preventative lab tests)*	$0 copay	CIF
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	$20 copay	Deductible, then CIF*
Well Child Care *(includes preventative lab tests)*	$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)
Routine GYN Exam *(one per calendar year, includes preventative lab tests)*	$0 copay	CIF
Routine Mammogram	$0 copay	CIF
Routine Vision Exam	Covered in full (once every 12 months)	Covered in full (once every 12 months)
Routine Maternity Care Office Visits	No charge for routine	Prenatal: Covered in full ; Postnatal: Cover in full after deductible
Specialist Office Visit	$45 copay	Deductible, then CIF*
OTHER OUTPATIENT	YOU PAY	YOU PAY
Durable Medical Equipment - Deductible applies where noted	Covered in full (after the deductible has been met)	Deductible, then CIF
Ambulance	$0 copay	Deductible, then CIF*
Routine Pediatric Dental	Covered in full: Preventive care for children under age 12 one visit each six months	Covered in full : children under age 12 one visit each six months.
Chiropractor Visits - Deductible applies where noted	$20 copay, maximum of 12 visits per plan year	Deductible, then CIF*. 12 visit limit per plan year

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BENEFIT	**Network Blue New England** **Network Blue Select (Limited Network)**	**Access Blue New England Saver**
Prescriptions	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	**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.	**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.)

*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.