WEST SUBURBAN HEALTH GROUP

BENCHMARK HEALTH PLAN COMPARISON CHART July 1, 2022

Effective 07-01-2022

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN
PLAN TYPE	**BENCHMARK**	**BENCHMARK**	**BENCHMARK**
^ CIF = Covered in Full	**CHOICENET**	**NETWORK BLUE NE**	
BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**
Lifetime Benefit Maximum	None	None	None
Deductible - applies to: In- patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - *See plan document for full details*	IND $300 FAM $900	IND $300 FAM $900	IND $300 FAM $900
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. Effective July 1, 2015, out-of-pocket maximums for prescription copays have been added as required by ACA (in- network only).	**Medical** - $2,000 per member / $4,000 per family per plan year **Prescription**- $2,000 per member / $4,000 per family per plan year See plan for details	**Medical** - $2,000 per member / $4,000 per family per plan year **Prescription**- $2,000 per member / $4,000 per family per plan year See plan for details	**Medical** - $2,000 per member / $4,000 per family per plan year **Prescription**- $2,000 per member / $4,000 per family per plan year See plan for details
Family Covered	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Member must select	Member must select	No selection required
Specialist Referrals	PCP must refer	PCP must refer	No referral required
Providers of Service	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies
Pre-existing Conditions	No restrictions	No restrictions	No restrictions
INPATIENT			
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Deductible applies then: Tier 1 : $250 Tier 2 :$500 Tier 3 : $1500 per/Admit NOTE-Mental Health/Substance Abuse copay $250	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay	Semi-private room & board & ancillary services Tier 1: $500 copay, then deductible applies Tier 2: $1500 copay, then deductible applies NOTE-Mental Health/Substance Abuse copay Tier 1: $500 then deductible
Physician Services	Nothing	Nothing	Nothing

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Skilled Nursing Facility	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then covered in full up to 100 days	Covered in Full after Deductible, up to 100 days per plan year
Newborn Well Baby Care (Inpatient)	Nothing	Nothing	Nothing
OUTPATIENT			
Emergency Room Visits for Emergency or Accident Care	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	$100 copay, then deductible applies (Inpatient copay applies if admitted)
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible applies, then $250 copay per visit	Deductible applies, then $250 copay per visit	$250 copay per outpatient surgery, then deductible
CT, MRI and Pet Scans	Deductible applies, then $100 Copay per procedure	Deductible, then $100 copay (scheduled outpatient)	$100 copay, then Deductible
Hemodialysis	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient	Deductible, then CIF^	Deductible, then CIF^
Physical Therapy	Copay: $20 per visit - Limited to 30 visits per plan year	$20 copay; up to 60 visits per calendar year (Unlimited for autism)	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year
Office Visits Primary Care Physician	$20 copay per visit	$20 copay per visit	$20 copay per visit
Preventive OV - PCP	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care *(Mental Health copays excluded from OOP max)*	$20 copay per visit	$20 copay per visit	$20 copay per visit
Office Visits Specialist	Tier 1: $30 copay per visit Tier 2: $60 copay per visit Tier 3: $90 copay per visit	$60 copay per visit	$60 copay per visit
OB/GYN	$20 copay per visit	$20 copay per visit	$20 copay per visit
GYN-Preventive Office visit	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	$0 copay - 1 every 2 years	$0 copay; one visit every 12 months	$20 copay per visit; one visit per plan year. Eyewear discounts available at participating providers.
Pre-Admission Testing -	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Nothing	Nothing	Routine is CIF, non routine subject to deductible

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Dental Services	**Children up to age 13** - Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	**Children under age 12**: Preventive dental one exam every six months., incl. cleaning, fluoride treatment and x-rays. **All members**: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed.	**Children under age 12**; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY
OTHER FEATURES			
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	Nothing when medically necessary	Not a covered benefit
Home Health Care	Member cost sharing depends on types of services provided and tier placement of provider rendering dervices, as listed in the Schedule of Benefits. For example, for services provided by a physician, see "physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."	Deductible, then CIF^	Deductible, then CIF^
Hospice Care	Same as Home Health Care	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	Deductible, then CIF^	Deductible, then 20% coinsurance	Covered in Full
Ambulance	Nothing when medically necessary	Deductible then covered in full	Covered in full when medically necessary
Radiation Therapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	$20 copay, 20 visits per plan year	$20 copay per visit. 12 visits maximum per calendar year	$20 copay per visit; up to 12 visits per plan year
Acupuncture	$30 copay, 12 visits per plan year	$60 copay, 12 visits per plan year	$20 copay, unlimited visits

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Prescription Drugs	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy:**
(Inpatient drugs paid in full)	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply)	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply)	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply)
	Mail Order: (90 day supply)	**Mail Order: (90 day supply)**	**Mail Order: (90 day supply)**
	Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay
Fitness Benefit	**Reimbursement**	**Reimbursement**	**Reimbursement**
	Fitness reimb up to **$150** per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.	Up to $300 reimbursement toward health club membership or exercise classes, or virtual online memberships, subscriptions, programs. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details.
	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM