WEST SUBURBAN HEALTH GROUP

Effective 07-01-2022

HEALTH PLAN COMPARISON CHART - all plans - July 1, 2022

	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD			TUFTS HEALTH PLAN	
PLAN TYPE	**PPO**		**BENCHMARK**	**HIGH DEDUCTIBLE**	**BENCHMARK**	**BENCHMARK**	**HIGH DEDUCTIBLE**	**BENCHMARK**	**HIGH DEDUCTIBLE**
^ CIF = Covered in Full	**IN-NETWORK**	**OUT-OF-NETWORK**	**CHOICENET**	**HSA ELIGIBLE**	**NETWORK BLUE NE**	**NETWORK BLUE SELECT**	**HSA ELIGIBLE**		**HSA ELIGIBLE**
BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Lifetime Benefit Maximum	None	None	None	None	None	None	None	None	None
Deductible - (Benchmark Plans only) 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*	None	IND $100/ FAM $200	IND $300 FAM $900	IND $2,000 FAM $4,000 (Non-embedded, plan year deductible, family plan deductible needs to be satisfied before insurance plan kicks in)	IND $300 FAM $900	IND $300 FAM $900	IND $2,000 FAM $4,000	IND $300 FAM $900	IND $2,000 FAM $4,000
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	None	**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 & RX COMBINED** - $5,000 per member $10,000 per family per plan year 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	**Medical & RX COMBINED** - $5,000 per member $10,000 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 & RX COMBINED** - $5,000 per member $10,000 per family per plan year, see plan for details
Family Covered	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children until age 26	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	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	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Any PCP in network	No selection required	Member must select	Member must select	Member must select	Member must select	Member must select	No selection required	Member must select
Specialist Referrals	Any HPHC Specialist	Any licensed specialist	PCP must refer	PCP must refer	PCP must refer	PCP must refer	No referral required	No referral required	PCP must refer

	HARVARD PILGRIM HEALTH CARE				BLUE CROSS BLUE SHIELD			TUFTS HEALTH PLAN	
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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Providers of Service	**HARVARD PILGRIM** providers - Members also have access to a wide range of participating providers through the Private Health Care Systems network while outside of MA, NH and ME	Any licensed provider; any hospital	**HARVARD PILGRIM** providers except in emergencies	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**HMO BLUE SELECT MA PROVIDERS ONLY** except in emergencies A Limited Network with Great Value HMO Blue Select features a smaller and very attracitve 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.	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
INPATIENT									
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Nothing	20% coinsurance after deductible	Deductible applies then: Tier 1 : $250 Tier 2 :$500 Tier 3 : $1500 per/Admit NOTE-Mental Health/Substance Abuse copay $250	Deductible, then CIF^	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay	Deductible, then CIF^	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	Deductible, then CIF^
Physician Services	Nothing	20% coinsurance after deductible	Nothing	Deductible, then CIF^	Nothing	Nothing	Deductible, then CIF^	Nothing	Deductible, then CIF^

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Skilled Nursing Facility	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then CIF^ up to 100 days per plan year	Deductible, then covered in full	Deductible, then covered in full	Deductible, then CIF^	Covered in Full after Deductible, up to 100 days per plan year	Deductible, then CIF^ up to 100 days
Newborn Well Baby Care (Inpatient)	Nothing	20% coinsurance after deductible	Nothing	Deductible, then CIF^	Nothing	Nothing	Nothing	Nothing	Deductible, then CIF^
OUTPATIENT									
Emergency Room Visits for Emergency or Accident Care	$40 copay, waived if admitted	$40 copay, waived if admitted	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, then CIF^	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	Deductible, then CIF^	$100 copay, then deductible applies (Inpatient copay applies if admitted)	Deductible, then CIF^
Outpatient Surgery in a Day Surgery facility or Hospital	Nothing	20% coinsurance after deductible	Deductible applies, then $250 copay per visit	Deductible, then CIF^	Deductible applies, then $250 copay per visit	Deductible applies, then $250 copay per visit	Deductible, then CIF^	$250 copay per outpatient surgery, then deductible	Deductible, then CIF^
CT, MRI and Pet Scans	Nothing	20% coinsurance after deductible	Deductible applies, then $100 Copay per procedure	Deductible, then CIF^	Deductible, then $100 copay (scheduled outpatient)	Deductible, then $100 copay (scheduled outpatient)	Deductible, then CIF^	$100 copay, then Deductible	Deductible, then CIF^
Hemodialysis	$5 copayment per visit	20% coinsurance after deductible	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient Services	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Physical Therapy	$5 copay per visit	20% coinsurance after deductible	Copay: $20 per visit - Limited to 30 visits per plan year	Deductible, then CIF^ Limited to 30 visits per plan year	$20 copay; up to 60 visits per calendar year (unlimited for autism)	$20 copay. PT / OT Max limit up to 60 visits per plan year	Deductible, then CIF^ 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	Deductible, then CIF^ 30 visits per plan year
Office Visits Primary Care Physician	$5 copay per visit	Not covered	$20 copay per visit	Deductible, then CIF^	$20 copay	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care *(Mental Health copays excluded from OOP max)*	$5 copay per visit	20% coinsurance after deductible	$20 copay per visit	Deductible, then CIF^	$20 per visit	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^
Office Visits Specialist	$5 copay per visit	20% coinsurance after deductible	Tier 1 : $30 copay per visit Tier 2: $60 copay per visit Tier 3: $90 copay per visit	Deductible, then CIF^	$60 copay per visit	$60 copay per visit	Deductible, then CIF^	$60 copay per visit	Deductible, then CIF^
OB/GYN	$5 copay per visit	20% coinsurance after deductible	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	$20 copay per visit	Deductible, then CIF^	$20 copay per visit	Deductible, then CIF^
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	20% coinsurance after deductible	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	$5 copay per visit; one visit per calendar year. $0 copay for children under 5 years of age Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers	$0 copay - 1 every 2 years	Deductible, then CIF^	$0 copay; one visit every 12 months	$0 copay per visit; one visit every 12 months	$0 copay; one visit every 12 months	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	Covered in Full-one visit every 12 months

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Pre-Admission Testing -	Nothing	20% coinsurance after deductible	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Nothing	20% coinsurance after deductible	Nothing	Routine OPD, Pre and Post Natal CIF^	Nothing	Nothing	Nothing for prenatal; all other serviceds Deductible, then CIF*	Nothing for prenatal and postnatal outpatient care, non routine deductibe, then CIF	Nothing for prenatal and postnatal outpatient care non routine deductiblel then CIF
Dental Services	**Children up to age 14 -** Covered in full for preventative care. **All members** - $5 copay for extraction of impacted teeth and initial emergency treatment.	**Children up to age 14 -** 20% coinsurance after deductible for preventative care. **All members** - 20% coinsurance after deductible for extraction of impacted teeth and initial emergency treatment.	**Preventative dental for children up to age 13** - Tier 1 Copayment per visit 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.	**Deductible, then 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**: 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**: 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. See Outpatient Surgery for benefit information.	**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	**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	20% coinsurance after deductible	Nothing when medically necessary	Deductible, then CIF^	Nothing when medically necessary	Nothing when medically necessary	Deductible, then CIF^	Not a covered benefit	Not a covered benefit
Home Health Care	Nothing	20% coinsurance after deductible	Member cost sharing depends on types of services provided and tier placement of provider rendering devices, as listed in the Schedule of Benefits	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Hospice Care	Nothing	20% coinsurance after deductible	Same as Home Health Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	20% of equipment cost to HPHC not to exceed a member's expense of $1000,	Deductible, then 20% of equipment cost to HPHC not to exceed a member's expense of $1000	Deductible, then CIF^	Deductible, then CIF^	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then CIF^	Covered in Full	Deductible, then CIF^
Ambulance	Nothing, when medically necessary	Nothing, when medically necessary	T1 deductible, then CIF	Deductible, then CIF^	Deductible then covered in full	Deductible then covered in full	Deductible, then CIF^	Covered in full when medically nceessary	Deductible, then CIF^
Radiation Therapy	Nothing	20% coinsurance after deductible	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Nothing	20% coinsurance after deductible	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	$5 copay per visit, up to $500 per calendar year	20% coinsurance after deductible	$20 copay, 20 visits per plan year	Deductible, then CIF^ 12 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.	Deductible, then CIF^ 12 visits per calendar year	$20 copay per visit; up to 12 visits per calendar year	Deductible, then CIF^ 12 visits per plan year
Acupuncture Visits	$5 Copayment per visit (12 visits per clendar year)	Deductible, then 20%	$30 copay. 12 visits per plan year	Deductible, then CIF 12 visits per plan year	$60 Copay, 12 visits per calendar year	$60 Copay, 12 visits per calendar year	Deductible, then CIF, 12 visits per calendar year	$20 Copay, unlimited visits	Deductible then CIF, unlimited visits
Prescription Drugs	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy:**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**
(Inpatient drugs paid in full)	Tier 1: $5 copay Tier 2: $10 copay Tier 3: $25 copay up to a 30 day supply **MedImpact Mail Order:** Tier 1: $10 copay Tier 2: $20 copay Tier 3: $75 copay up to a 90 day supply	Tier 1: $5 copay Tier 2: $10 copay Tier 3: $25 copay up to a 30 day supply **No mail order coverage except through** MedImpact Mail Order	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)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	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) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	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)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	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)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	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) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	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)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	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) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Fitness Benefit	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**	**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. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	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. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	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. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	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. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Up to $300 reimbursement toward health club membership and classes and/or virtual memberships and classes. See plan materials for details. Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $300 reimbursement toward health club membership and classes and/or virtual memberships and classes. See plan materials for details. Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Up to $300 reimbursement toward health club membership and classes and/or virtual memberships and classes. See plan materials for details. Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details. JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details. JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM