CCMHG *HSA Qualified High Deductible* Plan Benefit Comparison - FY24

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.

Effective 07-01-2023 **CIF = Covered In Full**	**BLUE CROSS BLUE SHIELD**			**HARVARD PILGRIM HEALTH CARE**		
		BLUE CARE ELECT PPO Saver			**PPO**	
BENEFIT	**HMO Blue New England Saver**	**In-Network**	**Out-of-Network**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible - Deductible to be satisfied , then Covered in Full, except prescription copays and out-of-network services. Per plan year (July 1 to June 30) - Single Paren/Single Child (SP/SC) plan design is the same as the Family plan. *Note* - the family plan Deductible must be satisfied before the plan begins to pay. **See plan document for full details**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**	**$2,000 per Individual plan** **$4,000 per Family plan**
Single Parent/Single Child (SP/S **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.	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family	**Medical & Rx Combined:** $5,000 per member $10,000 per family
Lifetime Benefit Maximum	None	None	None	None	None	None
INPATIENT	**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**	Deductible then Covered in Full (CIF)	Deductible then Covered in Full (CIF)	Deductible, then 20% coinsurance	Deductible then Covered in Full (CIF)	Deductible then Covered in Full (CIF)	Deductible, then 20% coinsurance
Physician Services	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Skilled Nursing Facility	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then 20% coinsurance to 100 days per calendar year benefit maximum	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then 20% coinsurance - limit to 100 days per plan year
Rehabilitation Hospital	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then 20% coinsurance to 60 days per calendar year benefit maximum	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then 20% coinsurance - limit to 60 days per plan year

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		BLUE CARE ELECT PPO Saver			**PPO**	
BENEFIT	**HMO Blue New England Saver**	**In-Network**	**Out-of-Network**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT HOSPITAL	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Emergency Room Visits for Emergency or Accident Care	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF
Emergency Room Visits for Medical Care	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF	Deductible then CIF
Surgery	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Radiation and Chemotherapy	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Diagnostic X-ray and Lab	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay	Deductible, then 20% coinsurance	$0 copay	$0 copay	Deductible, then 20% coinsurance
High Cost Radiology (MRI, CT & PET)	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Hemodialysis	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Physical Therapy	Deductible then Covered in Full (CIF) - up to 60 visits per calendar year	Deductible then Covered in Full (CIF) - up to 100 visits combined per calendar year	Deductible, then 20% coinsurance - up to 100 visits combined per calendar year	Deductible then Covered in Full (CIF) - up to 30 visits per plan year	Deductible then Covered in Full (CIF) - up to 30 visits per plan year	Deductible, then 20% coinsurance up to 30 visits per plan year
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Surgery	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance

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BENEFIT	**HMO Blue New England Saver**	**In-Network**	**Out-of-Network**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Adult Preventative Exam *as defined by the ACA*	CIF	CIF	Deductible, then CIF	CIF	CIF	20% coinsurance
PCP Medical Care/ **Mental Health Care/** **Substance Abuse Care**	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Well Child Care *as defined by the ACA*	CIF	CIF	Deductible, then 20% coinsurance	CIF	CIF	Deductible, then 20% coinsurance
Routine GYN Exam *(As defined by the ACA- one per calendar year , includes preventative lab tests)*	CIF	CIF	Deductible, then 20% coinsurance	CIF	CIF	Deductible, then 20% coinsurance
Routine Mammogram As defined by the ACA	CIF	CIF	Deductible, then 20% coinsurance	CIF	CIF	Deductible, then 20% coinsurance
Routine Vision Exam	CIF (once every 12 months)	CIF (once per calendar year)	20% coinsurance (once per calendar year)	CIF (1 visit per year)	CIF (1 visit per year)	20% coinsurance (1 visit per year)
Specialist Office Visit	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
OTHER OUTPATIENT						**YOU PAY**
Visiting Nurse **Home Health Care** **Deductible Applies**	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Durable Medical Equipment	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Ambulance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Emergency: Deductible then no charge Non Emergency: Deductible, then 20%
Routine Pediatric Dental	Nothing	All charges	All charges	Deductibe then CIF: Preventive care for children up to age 13. 2 visits per member per **plan** year including exam, cleaning, x-rays, & flouride treatment.	Deductible then CIF: Preventive care for children up to age 13. 2 visits per member per **plan** year including exam, cleaning, x-rays, & flouride treatment.	20% coinsurance

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BENEFIT	**HMO Blue New England Saver**	**In-Network**	**Out-of-Network**	**HPHC HMO**	**IN-NETWORK**	**OUT-OF-NETWORK**
Chiropractor Visits (limited to 20 visits per year)	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance
Prescription Drugs - IMPORTANT NOTE - Deductible applies, once deductible is met, copays will apply - NOTE- the drugs on the preventative list are not subject to the deductible. The lists are available at http://ccmhg.com/high-deductible-hsa-qualified-health-plans/	**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	**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 Benefit	Up to $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness. See plan 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 $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness. See plan 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 $150 reimbursement toward membership or exercise classes at a health club; and virtual fitness. See plan 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 $150 reimbursement per **calendar** year on fees for health and fitness club memberships, classes or virtual subscriptions. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active fitness club membership and HPHC member for at least four months within a calendar year.	Up to $150 reimbursement per **calendar** year on fees for health and fitness club memberships, classes or virtual subscriptions. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active fitness club membership and HPHC member for at least four months within a calendar year.	Up to $150 reimbursement per **calendar** year on fees for health and fitness club memberships, classes or virtual subscriptions. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement and active fitness club membership and HPHC member for at least four months within a calendar year.