

MNHG Health Plan Benefit Comparison

June 1, 2015 to May 31, 2016

Effective 06-01-2015

Benefit changes or clarifications in red font

BENEFIT	TUFTS HEALTH PLAN			FALLON COMMUNITY HEALTH PLAN	HARVARD PILGRIM HEALTH CARE		
	ADVANTAGE HMO	ADVANTAGE PPO		SELECTCARE & DIRECTCARE HMO PLANS [^] see footnote	HMO	PPO	
		In-Network	Out-of-Network			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 (June 1 to ,May 31) - See plan document for full details	\$250 per member \$750 per family	\$250 per member \$750 per family	\$400 per member \$800 per family	\$250 per member \$750 per family	\$250 per member \$750 per family	\$250 per member \$750 per family	\$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	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* Nothing for emergency/accident admissions	\$500 copay per admission after deductible for medical inpatient; substance abuse and mental health inpatient visits are covered in full	\$500 copay per admission	\$500 copay per admission	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	No copay up to 100 days per calendar year at a semi-private rate for each benefit	Limit to 100 days per Plan Year - \$500 copay per admission	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	No copay up to 100 days per calendar year at a semi-private rate for each benefit	Limit to 60 days per Plan Year - \$500 copay per admission	Limit to 60 days per Plan Year - \$500 copay per admission	20% coinsurance*

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		In-Network YOU PAY	Out-of-Network YOU PAY			IN-NETWORK YOU PAY	OUT-OF-NETWORK 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, (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, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted
Surgery - Deductible Applies	\$150 copay	\$150 copay	20% coinsurance*	\$150 copay	\$150 copay	\$150 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 (after the deductible has been met)	Covered in full (after the deductible has been met)	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 co-pay	\$100 co-pay	20% coinsurance*	\$100 co-pay	\$100 co-pay	\$100 co-pay	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	30 visits per Plan Year - \$20 copay per visit	30 visits per Plan Year - \$20 copay per visit	20% coinsurance* 30 visits per plan year

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		In-Network YOU PAY	Out-of-Network YOU PAY			IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY
PHYSICIAN'S OFFICE							
Surgery - NO Deductible	\$20 PCP copay and \$35 Specialist copay	\$20 PCP copay and \$35 Specialist copay	20% coinsurance*	\$20 PCP copay and \$35 Specialist copay	Copay Level 1 provider : \$20 per visit Copay Level 2 provider : \$35 per visit	Copay Level 1 provider : \$20 per visit Copay Level 2 provider : \$35 per visit	20% coinsurance*
Adult Preventative Exam <i>(includes preventative lab)</i>	\$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 <i>(includes preventative lab tests)</i>	\$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 <i>(one per calendar year, includes preventative lab tests)</i>	\$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)	\$0 copay (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	Prenatal: \$20 copay first visit only; Postnatal: \$20 copay per visit	\$20 copay (Initial copay only)	\$20 copay (Initial copay only)	20% coinsurance
Specialist Office Visit	\$35 copay	\$35 copay	20% coinsurance*	\$35 copay	\$35 copay	\$35 copay	20% coinsurance*
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
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*
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, no 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

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		In-Network	Out-of-Network	HMO PLANS [^] see footnote		IN-NETWORK	OUT-OF-NETWORK
Dental Benefit	No coverage	No coverage	No coverage	\$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals.	No coverage	No coverage	No coverage
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	\$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & fluoride treatment.	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & fluoride treatment.	All charges
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, maximum of 12 visits per year	No coverage	No coverage	No coverage
Prescription Drugs	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay Mail Order: (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay

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		In-Network	Out-of-Network			IN-NETWORK	OUT-OF-NETWORK
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	SELECTCARE - \$200 - Individual / \$400 Family - Reimbursement for Gyms, School and Town Sports to name a few. DIRECTCARE - \$250 - Individual / \$500 Family - Reimbursement for Gyms, School and Town Sports to name a few. WELLNESS - The Healthy Health Plan – An online wellness program that rewards all eligible members over the age of 18 for being, and becoming, healthy. Members simply visit fallonhealth.org/healthyhealthplan, fill out the health assessment, and if eligible, they will receive up to \$200. Members that need a little help getting healthier may participate in a customized health plan that includes health coaching, wellness workshops, interactive health tools, and more. Members that are already in excellent health also have access to the same tools to assist them in staying healthy.	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.	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.	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.
<p>*After Deductible</p> <p>^FCHP SELECTCARE AND DIRECTCARE PROVIDER NETWORKS - SEE BELOW</p> <p>Select Care is an expansive network that includes physician practices, community-based hospitals and medical facilities across Massachusetts and southern New Hampshire. Select Care offers greater choice at a competitive price. The Select Care service area includes all of Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties. With more than 35,000 providers, Select Care means more options and choices for you and your family.</p> <p>Direct Care is a limited provider network, including premier provider groups and community hospitals offering high-quality care at an affordable premium. These providers are chosen for their medical excellence, patient access and innovation. There are more than 22,000 participating providers in the Direct Care network.</p> <p>As a Direct Care member, if you ever should need a second opinion or the specialized expertise of Boston research and teaching hospitals, Fallon Direct Care offers access through our exclusive Peace of Mind Program™.</p> <p>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.</p>							