WEST SUBURBAN HEALTH GROUP

Effective 07-01-2022

HSA Qualified - HDHP HEALTH PLAN COMPARISON CHART July 1, 2022

red font indicates change or clarification PLAN TYPE	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN
^ CIF = Covered in Full	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP
BENEFIT	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None
Deductible - Once deductible is satisfied, all services CIF^ as noted, with the exception of Prescription Copays	IND $2,000 FAM $4,000 (Non-embedded, plan year deductible, family plan deductible needs to be satisfied before insurance plan kicks in)	IND $2,000 FAM $4,000	IND $2,000 FAM $4,000
Out-of-Pocket (OOP) Maximum-	**Medical & RX COMBINED** - $5,000 per member $10,000 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 & RX COMBINED** - $5,000 per member $10,000 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	Member must select
Specialist Referrals	PCP must refer	No referral required	PCP must refer
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, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Physician Services	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Skilled Nursing Facility	Deductible, then CIF^ up to 100 days per plan year	Deductible, then CIF^	Deductible, then CIF^ up to 100 days per plan year
Newborn Well Baby Care (Inpatient)	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
OUTPATIENT			
Emergency Room Visits for Emergency or Accident Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
CT, MRI and Pet Scans	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Hemodialysis	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Physical Therapy	Deductible, then CIF^ Limited to 30 visits per plan year	Deductible, then CIF^ Limited to 60 visits per member per calendar year for physical and occupational therapy (unlimited for autism)	Deductible, then CIF^ 30 visits per plan year

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Office Visits Primary Care Physician	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Preventive OV - PCP	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Office Visits Specialist	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
OB/GYN	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
GYN-Preventive Office visit	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	Deductible, then CIF^	Nothing. (once every 12 months)	CIF^ (one visit per plan yr)
Pre-Admission Testing -	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Routine OPD, Pre and Post Natal CIF^	Nothing for prenatal; all other serviceds Deductible, then CIF*	Routine care CIF^ Nonroutine subject to deductible
Dental Services	**Deductible, then 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 visit every 6 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
OTHER FEATURES			
Private Duty Nursing (only when medically necessary)	Deductible, then CIF^	Deductible, then CIF^	Not a covered benefit
Home Health Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Hospice Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Ambulance	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Radiation Therapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	Deductible, then CIF^ 12 visits per plan year	Deductible, then CIF^ 12 visits per calendar year	Deductible, then CIF^ 12 visits per plan year
Acupuncture	Deductible, then CIF^ 12 visits per plan year	Deductible, then CIF^ 12 visits per calendar year	Deductible, then CIF^ unlimited visits
Prescription Drugs	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**
(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) **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) 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) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay

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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 fitness 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