WEST SUBURBAN HEALTH GROUP

Effective 07-01-2024

BENCHMARK HEALTH PLAN COMPARISON CHART July 1, 2024

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	BLUE CROSS BLUE SHIELD
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE	NETWORK BLUE SELECT
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	Member must select
Specialist Referrals	PCP must refer	PCP must refer	PCP must refer
Providers of Service	**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.
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 deductible, then copay $250	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay

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Physician Services	Nothing	Nothing	Nothing
Skilled Nursing Facility	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then covered in full up to 100 days	Deductible, then covered in full up to 100 days
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	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
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible applies, then $250 copay per visit	Deductible applies, then $250 copay per visit	Deductible applies, then $250 copay per visit
CT, MRI and Pet Scans	Deductible applies, then $100 Copay per procedure	Deductible, then $100 copay (scheduled outpatient)	Deductible, then $100 copay (scheduled outpatient)
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)	$20 copay; up to 60 visits per calendar year (Unlimited for autism)
Office Visits Primary Care Physician	$20 copay per visit	$20 copay	$20 copay
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 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	$0 copay per visit; one visit every 12 months
	Eyewear discounts available at participating providers		
Pre-Admission Testing -	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Nothing	Nothing	Nothing

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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**: 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.
OTHER FEATURES			
Private Duty Nursing	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary
(only when medically necessary)			
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	Deductible, then 20% coinsurance
Ambulance	Deductible then covered in full	Deductible then covered in full	Deductible then covered in full
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	$60 copay, 12 visits per plan year
Prescription Drugs	**Retail Pharmacy:**	**Retail Pharmacy:**	**Retail Pharmacy:**
(Inpatient drugs paid in full)	Tier 1: $10.00 copay	Tier 1: $10.00 copay	Tier 1: $10.00 copay
	Tier 2: $30.00 copay	Tier 2: $30.00 copay	Tier 2: $30.00 copay
	Tier 3: $65.00 copay	Tier 3: $65.00 copay	Tier 3: $65.00 copay
	(up to a 30-day supply)	(up to a 30-day supply)	(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 1: $25.00 copay	Tier 1: $25.00 copay
	Tier 2: $75.00 copay	Tier 2: $75.00 copay	Tier 2: $75.00 copay
	Tier 3: $165.00 copay	Tier 3: $165.00 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, virtual online memberships, athletic fees, bicycles, helmets, athletic shoes. See plan materials for details.	Up to $300 reimbursement toward health club membership or exercise classes, virtual online memberships, athletic fees, bicycles, helmets, athletic shoes. See plan materials for details.
	Various Fitness, Exercise, and Weight Management discoutns available to members.	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.