## MINUTEMAN NASHOBA HEALTH GROUP (MNHG)

### IMPORTANT - PLEASE READ

The attached benefit comparison chart is a high level overview of the plans offered by MNHG.
The plan documents available to registered users on the carrier websites are the documents that describe full and complete plan details.
The carrier documents are the only documents that coverage is based on.
Should you have a question about specific coverage, you will need to contact the Member Service number on your ID card for detail or visit the carrier website.

# MNHG Health Plan Benefit Comparison

## June 1, 2019 to May 31, 2020

**Effective 06-01-2019**

**changes and/or clarifications in red font**

| | TUFTS HEALTH PLAN | | | FALLON COMMUNITY HEALTH PLAN | HARVARD PILGRIM HEALTH CARE | | |
|---|---|---|---|---|---|---|---|
| | | ADVANTAGE PPO | | SELECTCARE & DIRECTCARE | | PPO | |
| **BENEFIT** | **ADVANTAGE HMO** | **In-Network** | **Out-of-Network** | **HMO PLANS^***see footnote* | **HMO** | **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*** | $300 per member not to exceed $900 per family | $300 per member not to exceed $900 per | $400 per member $800 per family | $300 per member not to exceed $900 per family | $300 per member not to exceed $900 per | $300 per member not to exceed $900 per | $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 $6,000 per Family | **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* | $500 copay per admission, **then** deductible for medical inpatient; substance abuse and mental health inpatient visits are covered in full | $500 copay per admission then deductible for medical inpatient; substance abuse and mental health inpatient visits are covered in full | $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 | **CIF after deductible**, up to 100 days per plan year at a semi-private rate for each benefit | CIF after deductible, up to 100 days per plan year at a semi-private rate for each benefit | 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 | **CIF after deductible**, up to 100 days per plan year at a semi-private rate for each benefit | CIF after deductible, up to 100 days per plan year at a semi-private rate for each benefit | Limit to 60 days per Plan Year - $500 copay per admission | 20% coinsurance* |

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|---|---|---|---|---|---|---|---|
| | | ADVANTAGE PPO | | SELECTCARE & DIRECTCARE | | PPO | |
| **BENEFIT** | ADVANTAGE HMO | In-Network | Out-of-Network | HMO PLANS^*see footnote* | HMO | IN-NETWORK | OUT-OF-NETWORK |
| **OUTPATIENT** | YOU PAY | YOU PAY | YOU PAY | YOU PAY | YOU PAY | YOU PAY | 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, then deductible, (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, then deductible, waived if admitted | $100 copay, waived if admitted | $100 copay, waived if admitted |
| **Surgery - Deductible Applies** | $250 copay | $250 copay | 20% coinsurance* | $250 copay | $250 copay | $250 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, then deductible | $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 | $20 co-pay up to 60 visits per plan year | 30 visits per Plan Year - $20 copay per visit | 20% coinsurance* 30 visits per plan year |
| **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* |
| **Dental Benefit** | No coverage | No coverage | No coverage | $10 copay for exam, cleaning, x-rays every 6 months.<br>Variable copays for minor restorative (fillings).<br>25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures.<br>Must use participating dentists. | No coverage | No coverage | No coverage |

# MNHG Health Plan Benefit Comparison

## June 1, 2019 to May 31, 2020

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|---|---|---|---|---|---|---|---|
| | | ADVANTAGE PPO | | SELECTCARE & DIRECTCARE | | PPO | |
| **BENEFIT** | **ADVANTAGE HMO** | **In-Network** | **Out-of-Network** | **HMO PLANS^***see footnote*** | **HMO** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **PHYSICIAN'S OFFICE** | **YOU PAY** | **YOU PAY** | **YOU PAY** | **YOU PAY** | **YOU PAY** | **YOU PAY** | **YOU PAY** |
| **Surgery - NO Deductible** | $20 PCP copay and $45 Specialist copay | $20 PCP copay and $45 Specialist copay | 20% coinsurance* | $20 PCP copay and $45 Specialist copay | Copay Level 1 provider : $20 per visit<br>Copay Level 2 provider : $35 per visit | Copay Level 1 provider : $20 per visit<br>Copay Level 2 provider : $35 per visit | 20% coinsurance* |
| **Adult Preventative Exam** *(includes preventative lab tests)* | $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** *(includes preventative lab tests)* | $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** *(one per calendar year, includes preventative lab tests)* | $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) | Covered in full (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: Covered in full ; Postnatal: Cover in full after deductible | $20 copay (Initial copay only) | $20 copay (Initial copay only) | 20% coinsurance |
| **Specialist Office Visit** | $45 copay | $45 copay | 20% coinsurance* | $45 copay | $45 copay | $45 copay | 20% coinsurance* |
| **OTHER OUTPATIENT** | **YOU PAY** | **YOU PAY** | **YOU PAY** | **YOU PAY** | **YOU PAY** | **YOU PAY** | **YOU PAY** |
| **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, after 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 |
| **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.<br>Variable copays for minor restorative (fillings).<br>25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures.<br>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, & flouride treatment. | Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & flouride 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, maxium of 12 visits per plan year | No coverage | No coverage | No coverage |

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| | | ADVANTAGE PPO | | SELECTCARE & DIRECTCARE | | PPO | |
| **BENEFIT** | **ADVANTAGE HMO** | **In-Network** | **Out-of-Network** | **HMO PLANS^***see footnote* | **HMO** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Prescription Drugs** | Retail: (30 day supply)<br>Tier 1: $10.00 copay<br>Tier 2: $30.00 copay<br>Tier 3: $65.00 copay<br>Mail Order:<br>(90 day supply)<br>Tier 1: $25.00 copay<br>Tier 2: $75.00 copay<br>Tier 3: $165.00 copay | Retail: (30 day supply)<br>Tier 1: $10.00 copay<br>Tier 2: $30.00 copay<br>Tier 3: $65.00 copay<br>Mail Order:<br>Tier 1: $25.00 copay<br>Tier 2: $75.00 copay<br>Tier 3: $165.00 copay | Retail: (30 day supply)<br>Tier 1: $10.00 copay<br>Tier 2: $30.00 copay<br>Tier 3: $65.00 copay<br>Mail Order:<br>Tier 1: $25.00 copay<br>Tier 2: $75.00 copay<br>Tier 3: $165.00 copay | Retail: (30 day supply)<br>Tier 1: $10.00 copay<br>Tier 2: $30.00 copay<br>Tier 3: $65.00 copay<br>Mail Order: (90 day<br>Tier 1: $25.00 copay<br>Tier 2: $75.00 copay<br>Tier 3: $165.00 copay | Retail: (30 day supply)<br>Tier 1: $10.00 copay<br>Tier 2: $30.00 copay<br>Tier 3: $65.00 copay<br>Mail Order:<br>Tier 1: $25.00 copay<br>Tier 2: $75.00 copay<br>Tier 3: $165.00 copay | Retail: (30 day supply)<br>Tier 1: $10.00 copay<br>Tier 2: $30.00 copay<br>Tier 3: $65.00 copay<br>Mail Order:<br>Tier 1: $25.00 copay<br>Tier 2: $75.00 copay<br>Tier 3: $165.00 copay | Retail: (30 day supply)<br>Tier 1: $10.00 copay<br>Tier 2: $30.00 copay<br>Tier 3: $65.00 copay<br>Mail Order:<br>Tier 1: $25.00 copay<br>Tier 2: $75.00 copay<br>Tier 3: $165.00 copay |
| **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 | It Fits! Program reimburses families on Select Care up to $400 per family contract ($200 for individual contracts)and Direct Care members up to $500 per family contract ($250 for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment. **WELLNESS -** The Healthy Health Plan – An online wellness program that rewards subscribers and their covered spouses for being, and becoming, healthy. Members simply visit fallonhealth.org/healthyhealthplan , fill out the health assessment, and if eligible, they will receive **up to $100**. Members that need a little help getting healthier may participate in interactive health tools, health coaching, 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. |

***After Deductible**

### ^FCHP SELECTCARE AND DIRECTCARE PROVIDER NETWORKS - SEE BELOW

**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.**

**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.**
**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 ProgramTM.**

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.