BERKSHIRE HEALTH GROUP (BHG)

IMPORTANT - PLEASE READ

The attached benefit comparison chart is a high level overview of the plans offered by BHG.

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.

BERKSHIRE HEALTH GROUP

HSA Qualified Health Plans - BENEFIT COMPARISON - effective 7/1/19-6/30/20

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) and applicable riders define the terms and conditions of these benefits in greater detail. Should any questions arise, the Certificate(s) and riders will govern.

effective July 1, 2019	**HMO**	**PPO**	
	ACCESS BLUE NEW ENGLAND SAVER PLAN	**BLUE CARE ELECT SAVER PLAN**	
BENEFIT		**IN-NETWORK**	**OUT-OF-NETWORK***
Deductible (calculated on a plan year, 7/1 to 6/30)	$2,000 Individual $4,000 Family *(The total family deductible must be paid out-of-pocket before the insurer starts paying for healthcare services for any individual member)*	$2,000 Individual (Accumulates along with out-of-network amounts) $4,000 Family (Accumulates along with out-of-network amounts) (The total family deductible must be paid out-of-pocket before the insurer starts paying for healthcare services for any individual member)	$2,000 Individual (Accumulates along with in-network amounts) $4,000 Family (Accumulates along with in-network amounts) (The total family deductible must be paid out-of-pocket before the insurer starts paying for healthcare services for any individual member)
Out of Pocket (OOP) Maximum -	Combined Medical & Rx $5,000 Individual $10,000 Family	Combined Medical & Rx $5,000 Individual (Accumulates with out-of-network amounts) $10,000 Family (Accumulates with out-of-network amounts)	Combined Medical & Rx $5,000 Individual (Accumulates with in-network amounts) $10,000 Family (Accumulates with in-network amounts)
Lifetime Benefit Maximum	None	None	None
INPATIENT			
	YOU PAY	**YOU PAY**	**YOU PAY**
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room & board & special services)	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Physician Services	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Skilled Nursing Facility	Nothing after Deductible to 100 days per calendar year benefit maximum	Nothing after Deductible to 100 days per calendar year benefit maximum combined with out-of-network days	20% coinsurance to 100 days per calendar year benefit maximum combined with in-network days
Rehabilitation Hospital	Nothing after Deductible to 60 days per calendar year benefit maximum	Nothing after Deductible to 60 days per calendar benefit maximum combined with out-of-network days	20% coinsurance to 60 days per calendar year benefit maximum combined with in-network days

BENEFIT	ACCESS BLUE NEW ENGLAND SAVER PLAN	BLUE CARE ELECT SAVER PLAN	
		IN-NETWORK	OUT-OF-NETWORK*
OUTPATIENT			
Emergency Room Visits for Emergency or Accident care	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Outpatient Surgery	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Radiation and Chemotherapy	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
MRI, Pet Scans, CT Scans	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Hemodialysis	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Physical Therapy (Outpatient PT & OT (100 visits/year combined)	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance (100 in and out of network visits combined)
Physician Office	Deductible, then CIF** (Preventative care as defined by ACA, incl. routine physical CIF**)	Deductible, then CIF** (Preventative care as defined by ACA, incl. routine physical CIF**)	Deductible, then 20% coinsurance (Preventative care as defined by ACA, incl. routine physical
Surgery - Office	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Well Child Care	$0 per visit	$0 per visit; 10 visits 1st year; 3 visits 2nd year; 2 visit per year age 2; 1 visit every year ages 3 and older	20% coinsurance*; 10 visits 1st year; 3 visits 2nd year; 2 visit per year age 2; 1 visit every year ages 3 and older
Mental Health Care, Substance Abuse Care	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Routine GYN Exam	Deductible, then CIF** (Preventative care as defined by ACA, CIF**, 1 visit per calendar year)	Deductible, then CIF** (Preventative care as defined by ACA, CIF**, 1 visit per calendar year)	Deductible, then 20% coinsurance** (Preventative care as defined by ACA, CIF**, 1 visit per calendar year)
Routine Vision Exam	Deductible, then CIF** (Preventative care as defined by ACA, CIF**, 1 visit per calendar year)	Deductible, then CIF** (Preventative care as defined by ACA, CIF**, 1 visit per calendar year)	Deductible, then 20% coinsurance** (Preventative care as defined by ACA, CIF**, 1 visit per calendar year)
Visiting Nurse/Home Health Care	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance

BENEFIT	ACCESS BLUE NEW ENGLAND SAVER PLAN	BLUE CARE ELECT SAVER PLAN	
		IN-NETWORK	OUT-OF-NETWORK*
OTHER OUTPATIENT			
	YOU PAY	**YOU PAY**	**YOU PAY**
Durable Medical Equipment	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 40% coinsurance
Ambulance	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance, nothing for emergency
Routine Pediatric Dental (through age 11)	Deductible, then CIF** (Preventative care as defined by ACA, CIF**, 1 exam and cleaning every 12 months)	All charges	All charges
Chiropractor Visits (up to 20 visits per year)	Deductible, then CIF**	Deductible, then CIF**	Deductible, then 20% coinsurance
Prescription Drugs **(After deductible is met)**	**Retail** - up to 30 day supply $10 generic; $30 brand; $65 non-preferred brand **Mail Order** up to 90 day supply $25/$75/$165 **Medications listed on the Blue Cross Blue Shield of MA Preventive Medication List are not subject to deductible**	**Retail** - up to 30 day supply $10 generic; $30 brand; $65 non-preferred brand **Mail Order** up to 90 day supply $25/$75/$165 **Medications listed on the Blue Cross Blue Shield of MA Preventive Medication List are not subject to deductible**	**Retail** - up to 30 day supply $20 generic; $60 brand; $130 non-preferred brand **Medications listed on the Blue Cross Blue Shield of MA Preventive Medication List are not subject to deductible**

	ACCESS BLUE NEW ENGLAND SAVER PLAN	BLUE CARE ELECT SAVER PLAN	
		IN-NETWORK	OUT-OF-NETWORK*
WELLNESS REIMBURSEMENT BENEFIT			
	YOU PAY	**YOU PAY**	**YOU PAY**
WeightWatchers®	Up to $150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals.	Up to $150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals.	Up to $150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals.
Fitness Program	Up to $300 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs.	Up to $300 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs.	Up to $300 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs.

*** You may be billed by the provider for the charges above the allowed amount** **** CIF=Covered in Full**
Employers may contribute up to 50% of the deductible to the employee's HSA
Dependent Eligibility - Adult children covered up to the last day of the month of their 26th birthday