Fiscal Year 2024 – 2025

MAYFLOWER MUNICIPAL HEALTH GROUP

HMO COMPARISON OF BENEFITS

Comparison of the following HMO medical plans:

BCBSMA NETWORK BLUE HMO TRADITIONAL

BCBSMA NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER
BCBSMA NETWORK BLUE NE HMO BENCHMARK
HPHC HMO TRADITIONAL
HPHC HMO RATE SAVER
HPHC HMO CHOICENET BENCHMARK

BCBSMA=BLUE CROSS BLUE SHIELD OF MASSACHUSETTS

HPHC=HARVARD PILGRIM HEALTH CARE

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care (HMO) Options

Effective 7-1-2024

	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE		
BENEFIT	**NETWORK BLUE HMO TRADITIONAL**	**NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER**	**NETWORK BLUE NE DEDUCTIBLE HMO BENCHMARK PLAN**	**HPHC HMO TRADITIONAL**	**HPHC HMO RATE SAVER**	**HPHC CHOICENET HMO BENCHMARK**
Deductible	None	None	$300 per member per Plan Year $900 per family per Plan Year	None	None	$300 per member per Plan Year $900 per family per Plan Year
Out of Pocket (OOP) Maximum-Plan Year	$2,000 per member/$4,000 per family (per plan year) for Medical benefits $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits OOP is for all services except - premiums, balance-billed charges, and health care this plan doesn't cover.	$2,000 per member/$4,000 per family (per plan year) for Medical benefits $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits OOP is for all services except - premiums, balance-billed charges, and health care this plan doesn't cover.	$2,000 per member/$4,000 per family (per plan year) for Medical benefits $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits OOP is for all services except - premiums, balance-billed charges, and health care this plan doesn't cover.	$2,000 per member/$4,000 per family (per plan year) for Medical benefits AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits Out of pocket max. for all services	$2,000 per member/$4,000 per family (per plan year) for Medical benefits AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits Out of pocket max. for all services	$2,000 per member/$4,000 per family (per plan year) for Medical benefits AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits Out of pocket max. for all services
Eligible Dependents	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.
Service Area- (check participating providers online)	MA	Service area includes the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine. Based on where selected PCP is located.	Service area includes the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine. Based on where selected PCP is located.	MA, NH, ME, RI, and VT ***(CT no longer in service area effective 1/1/2024)***	MA, NH, ME, RI, and VT ***(CT no longer in service area effective 1/1/2024)***	MA, NH, ME, RI, and VT ***(CT no longer in service area effective 1/1/2024)***

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care (HMO) Options

Effective 7-1-2024	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE		
BENEFIT	**NETWORK BLUE HMO TRADITIONAL**	**NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER**	**NETWORK BLUE NE DEDUCTIBLE HMO BENCHMARK PLAN**	**HPHC HMO TRADITIONAL**	**HPHC HMO RATE SAVER**	**HPHC CHOICENET HMO BENCHMARK**
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
INPATIENT						
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)	Nothing	$250 per admission (including maternity care)	General Hosp: $500 per admit after deductible Higher Cost share Hosp: $1,500 per admit after deductible $200 per admission after deductible for Mental Hosp or Substance Abuse Hosp.	Nothing	$250 per admission	$500 Tier 1 copay after deductible $500 Tier 2 copay after deductible $1,500 Tier 3 copay after Tier 1 deductible then $200 per admission for Mental Hospital or Substance Abuse Hospital
Physician Services, Surgical Charges, Anesthesia and Consultations.	Nothing	Nothing	Nothing after deductible	Nothing	Nothing	Nothing
Skilled Nursing Facility	Nothing up to 100 days per member per plan year at a semi-private rate	Nothing up to 100 days per member per plan year at a semi-private rate	Nothing after deductible up to 100 days per plan year	Nothing up to 100 days per plan year at a semi-private rate for each benefit	Nothing up to 100 days per plan year at a semi-private rate for each benefit	Deductible then 20% coinsurance up to 100 days per plan year
Rehabilitation Hospital	Nothing to 60 days per plan year benefit maximum	Nothing to 60 days per plan year benefit maximum	Nothing after deductible up to 60 days per plan year benefit maximum	Covered in full when medically necessary and authorized by a plan physician - up to 60 days per plan year	Covered in full when medically necessary and authorized by a plan physician - up to 60 days per plan year	Deductible then no charge when medically necessary
OUTPATIENT HOSPITAL						
Emergency Room Visits for Emergency or Accident Care	$75 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay after deductible (waived if admitted)	$75 copay (waived if admitted)	$100 copay (waived if admitted)	Deductible then $100 copay (waived if admitted)
OutPatient Surgery	Nothing if performed at Hospital or Day Surgical Facility	$150 per admission surgical facility, hospital, or surgical day care unit	$250 after deductible per admission at surgical facility, hospital, or surgical day care unit	Nothing	$150 per admission	Deductible then $250 copay
Radiation and Chemotherapy	Nothing	Nothing	Nothing after deductible	Nothing	Nothing	Deductible then no charge
Diagnostic X-ray & Lab	Nothing	Nothing	Nothing after deductible	Nothing	Nothing	Deductible then no charge

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care (HMO) Options

Effective 7-1-2024	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE		
BENEFIT	**NETWORK BLUE HMO TRADITIONAL**	**NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER**	**NETWORK BLUE NE DEDUCTIBLE HMO BENCHMARK PLAN**	**HPHC HMO TRADITIONAL**	**HPHC HMO RATE SAVER**	**HPHC CHOICENET HMO BENCHMARK**
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
High Tech Radiology (MRI, CT, PT Scans)	Nothing	$100 per category per date of service out of pocket maximum is $375 per member per calendar year (copay waived at free-standing facilities)	$100 copayment per category per date of service after deductible ($375 maximum copayment amount per member per calendar year)(copay waived at free-standing facilities)	Nothing	$100 copayment per procedure (Copay waived at free-standing facilities)	Deductible then $100 per procedure (Copay waived at free-standing facilities)
Hemodialysis	Nothing	Nothing	Nothing after deductible	$15 copay	Nothing	Deductible then no charge
Physical Therapy	$15 copay up to 60 visits per member per plan year.	$35 copay up to 60 visits per member per plan year.	$20 copay up to 60 vists per member per plan year	$15 co-pay per visit; 60 visits PT/OT per plan year	$20 co-pay per visit; 60 visits PT/OT per plan year	$20 copay per visit 60 visits PT/OT per plan year
PHYSICIAN'S OFFICE						
PCP OV						
Tier 1	$15 copay	$20 copay	$20 copay	$15 copay	$20 copay	$20 copay
Tier 2	No tiering	No tiering	No tiering	No tiering	No tiering	$20 copay
Tier 3	No tiering	No tiering	No tiering	No tiering	No tiering	$20 copay
Specialist OV						
Tier 1	$15 copay	$35 copay	$60 copay	$15 copay	$35 copay	$60 copay
Tier 2	No tiering	No tiering	No tiering	No tiering	No tiering	$60 copay
Tier 3	No tiering	No tiering	No tiering	No tiering	No tiering	$60 copay
Mental Health Care, Substance Abuse Care	$15 copay	$20 copay	$20 copay	$15 copay	$20 copay	$20 copay
Well Child Care- up to Age 19	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Adult Routine Physicals- Age 19 and over	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Routine GYN Exam- 1 visit per plan year	Nothing - 1 visit per plan year	Nothing - 1 visit per plan year	Nothing - 1 visit per plan year	Nothing	Nothing	Nothing
Routine Colonoscopy (without surgery)	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care (HMO) Options

Effective 7-1-2024	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE		
BENEFIT	**NETWORK BLUE HMO TRADITIONAL**	**NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER**	**NETWORK BLUE NE DEDUCTIBLE HMO BENCHMARK PLAN**	**HPHC HMO TRADITIONAL**	**HPHC HMO RATE SAVER**	**HPHC CHOICENET HMO BENCHMARK**
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Routine Mammogram	Nothing -One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.	Nothing -One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.	Nothing -One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.	Nothing	Nothing	Nothing
Routine Vision Exam **Preventative Vision Exam**	Nothing - 1 visit per member every 12 months	Nothing - 1 visit per member every 12 months	Nothing - 1 visit every 24 months	$15 copay (1 visit per plan year)	$20 copay (1 visit per plan year)	Nothing - 1 visit every 2 Plan years
Family Planning Services	Nothing	Nothing	Nothing	Member cost share depends on type of service provided (contraception/counseling covered in full/ Infertility services, $15 copay per visit)	Member cost share depends on type of service provided (contraception/counseling covered in full/ Infertility services, $20 copay per visit)	Member cost share depends on type of service provided (contraception/counseling covered in full/ Infertility OVs, applicable copay/ treatments and procedures, deductible, then nothing)
OTHER OUTPATIENT						
Visiting Nurse **Home Health Care**	Nothing	Nothing	Nothing after deductible	Nothing	Nothing	Member cost share depends on type of service provided and the tier placement of the provider rendering services. Deductible, then no charge
Hospice Services	Nothing	Nothing	Nothing after deductible	Nothing	Nothing	Deductible then nothing
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	$15 copay	$35 copay	$60 copay	$15 copay	$20 Copay PCP (level1) $35 copay Outpatient-(level 2)	Deductible then no charge
Durable Medical Equipment	20% (no dollar max) (prosthetics at 20% with no maximum)	20% (no dollar max) (prosthetics at 0% with no maximum)	20% after deductible (no dollar max)	Covered in Full no benefit limit	Covered in Full no benefit limit	Deductible then no charge (no benefit limit)
Ambulance (when medically necessary)	Nothing	Nothing	Nothing after deductible	Nothing	Nothing	Deductible then no charge

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care (HMO) Options

Effective 7-1-2024	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE		
BENEFIT	**NETWORK BLUE HMO TRADITIONAL**	**NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER**	**NETWORK BLUE NE DEDUCTIBLE HMO BENCHMARK PLAN**	**HPHC HMO TRADITIONAL**	**HPHC HMO RATE SAVER**	**HPHC CHOICENET HMO BENCHMARK**
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Dental Care	$10 copay per visit for all members. One cleaning every 6 months. Includes x-rays, oral exams and fillings. $300 plan year max for members age 19 and over. **Must use Dental Blue PPO Network Provider.**	Not covered except for members under 18 to treat cleft lip and cleft palate.	Not covered except for preventive dental care for members under 18 to treat cleft lip and cleft palate (no cost)	$0 copay preventive care for children up to age 13. 2 visits per plan year including exam, cleaning, x-rays, & fluoride treatment. $15 copay for extraction of unerupted teeth impacted in bone in an office setting and initial emergency treatment.Must see a network provider. THIS IS A PEDIATRIC DENTAL RIDER AND COVERAGE IS LIMITED SEE SUMMARY FOR DETAILS	$0 copay preventive care for children up to age 13; 2 visits per plan year including exam, cleaning, x-rays, & fluoride treatment; $35 copay for extraction of unerupted teeth impacted in bone in an office setting and initial emergency treatment. Must see a network provider. THIS IS A PEDIATRIC DENTAL RIDER AND COVERAGE IS LIMITED SEE SUMMARY FOR DETAILS	Tier 1 Primary care copay: $20 per visit for preventative Dental care for children up to age 13; 2 visits per plan year including exam, cleaning, x-rays, & fluoride treatment; Deductible then no charge for extraction of unerupted teeth impacted in bone in an office setting and initial emergency treatment. Must see a network provider. THIS IS A PEDIATRIC DENTAL RIDER AND COVERAGE IS LIMITED SEE SUMMARY FOR DETAILS
Chiropractor Visits	$15 copay per visit - 12 visits per plan year	$35 copay per visit	$20 copay per visit	$15 copay per visit - 12 visits per plan year	$20 copay per visit -12 visits per plan year.	$20 copay per visit (20 visits per plan year)
Hearing Aids	Nothing - $2,000 per ear every 36 months for members 21 and under Benefit limit	Nothing - $2,000 per ear every 36 months for members 21 and under Benefit limit	Nothing - $2,000 per ear every 36 months for members 21 and under Benefit limit (Not subject to deductible)	No Charge Limited to $2000 per hearing aid every 36 months for each ear, for members up to age 22	No Charge Limited to $2000 per hearing aid every 36 months for each ear, for members up to age 22	No Charge Limited to $1,500 per hearing aid every 2 plan years for each ear. No age restriction applies
Acupuncture	$15 copay per visit - 12 visits per member per plan year	$35 copay per visit - 12 visits per member per plan year	$60 copay per visit - 12 visits per member per plan year (Deductible and or coinsurance not applicable)	$15 copay 12 visits per plan year at Participating providers	$20 copay 12 visits per plan year at Participating providers	$20 copay 12 visits per plan year at Participating providers
Prescription Drugs (See also *CanaRx program for certain brand named prescriptions with no cost share)	Formulary drugs: Tier 1: $10 copay Tier 2: $20 copay Tier 3: $35 copay Mail Order/CVS: Tier 1: $20 copay Tier 2: $40 copay Tier 3: $70 copay 30-day supply retail pharmacy or 90-day supply mail service/CVS retail locations Non-formulary drugs: all charges	Formulary drugs: Tier 1: $10 copay Tier 2: $25 copay Tier 3: $45 copay Mail Order/CVS: Tier 1: $20 copay Tier 2: $50 copay Tier 3: $90 copay 30-day supply retail pharmacy or 90-day supply mail service/CVS retail locations Non-formulary drugs: all charges	Formulary drugs: Tier 1: $10 copay Tier 2: $30 copay Tier 3: $65 copay Mail Order/CVS: Tier 1: $25 copay Tier 2: $75 copay Tier 3: $165 copay 30-day supply retail pharmacy or 90-day supply mail service/CVS retail locations Non-formulary drugs: all charges	Retail: Tier 1: $10 copay Tier 2: $20 copay Tier 3: $35 copay Mail Order: Tier 1: $20 copay Tier 2: $40 copay Tier 3: $105 copay 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges	Retail: Tier 1: $10 copay Tier 2: $25 copay Tier 3: $45 copay Mail Order: Tier 1: $20 copay Tier 2: $50 copay Tier 3: $90 copay 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges	Retail: Tier 1: $10 copay Tier 2: $30 copay Tier 3: $65 copay Mail order: Tier 1: $25 copay Tier 2: $75 copay Tier 3: $165 copay 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care (HMO) Options

Effective 7-1-2024	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE		
BENEFIT	**NETWORK BLUE HMO TRADITIONAL**	**NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER**	**NETWORK BLUE NE DEDUCTIBLE HMO BENCHMARK PLAN**	**HPHC HMO TRADITIONAL**	**HPHC HMO RATE SAVER**	**HPHC CHOICENET HMO BENCHMARK**
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Telemedicine- Virtual visits available on your computer, tablet or smart phone for medical care and behavioral health	$15 Copay per visit with a Well Connection Provider or a Doctor in the BCBSMA Network that provides Telemedicine Services	$20 or $35 copay (depending on provider) with a Well Connection Provider or a Doctor within the BCBSMA Network that provides Telemedicine Services	$20 or $60 copay (depending on provider) with a Well Connection Provider or a Doctor within the BCBSMA Network that provides Telemedicine Services	Virtual visits available through Doctor on Demand and for HPHC providers who provide telemedicine visits. $15 Copay	Virtual visits available through Doctor on Demand and for HPHC providers who provide telemedicine visits. $20 Copay for DoD and Level 1 providers/ $35 for Level 2	Virtual visits available through Doctor on Demand and for HPHC providers who provide telemedicine visits. $20 Copay for DoD and Level 1 providers/ $60 for Level 2
	Benefit	**Benefit**	**Benefit**	**Benefit**	**Benefit**	**Benefit**
OTHER BENEFITS						
Fitness Benefit/Special Programs	Up to $300 reimbursement toward membership or exercise classes at a health club or virtual fitness memberships or classes or home fitness equipment. Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees. ***New for 2024 Enhanced Fitness Benefits: •Bicycles/Bicycle Helmets - Bicycles that are purchased for recreational use and bicycle helmets. •Athletic Shoes- Athletic shoes designed to be worn for sports, exercising, or recreational activity. •Sports Activity Fees- Sports activity fees including (but not limited to): ski passes, fees for sports leagues (such as town sports, tennis, golf, or basketball), and race participation fees.***			Up to $300 reimbursement per calendar year ***towards:*** ***•Gym membership*** ***•Exercise classes*** ***•Virtual fitness subscriptions*** ***•Town, club, school athletic fees*** ***•Various nutritional and mindfulness apps*** 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. Free Eyeware at Visionworks and discounts at participating EyeMed affiliated providers with eye exam. Discounts on health education and approved nutrition counseling. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees. ***Reimbursement of up to $150 per calendar year for childbirthing classes.***		
Mind and Body Reimbursement	Up to $300 reimbursement per family per Calendar Year for Holistic Health such as Massage Therapy, Tai Chi, Hypnosis Therapy, Qi (chi) gong, Meditation Therapy and Breathing and meditation apps. You can also receive 30% off standard rates when you use an alternative health practitioner in the BCBSMA Network.			N/A		
*CanaRx Prescription Savings Program- https://www.canarx.com/plan/?planid=MMHG	Program eligible for certain Brand Name maintenance prescriptions at no cost- visit https://www.canarx.com/plan/?planid=MMHG			Program eligible for certain Brand Name maintenance prescriptions at no cost- visit https://www.canarx.com/plan/?planid=MMHG		
SmartShopper Incentive Program	SmartShopper program eligible-Shop for high quality providers and get rewarded			Not eligible	Not eligible	Not eligible
Learn to Live- confidential online cognitive behavioral therapy	Free confidential 24/7 online cognitive behavioral therapy for Worry, Stress, Anxiety, Depresession, Insomnia, Panic, Resilience, Substance Abuse. All employees and their family members (age 13 and over) are eligible. Visit learntolive.com/partners and enter the code MMHG. Take a quick free confidential assessment.					
MMHG Wellness Program	***QUARTERLY NEWSLETTER, WELLNESS SEMINARS/SCREENINGS/WEBINARS/CHALLENGES, INCENTIVE PROGRAMS, ON DEMAND VIRTUAL FITNESS & MINDFULNESS CLASSES/NUTRITION/SLEEP, HEALTHY RESOURCES WEBSITE/INSTAGRAM & MORE*** (PARTICIPATION IN CERTAIN PROGRAMS MAY VARY BY MEMBER UNIT. PLEASE CHECK WITH YOUR BENEFIT COORDINATOR OR WELLNESS COORDINATOR AND OUR WEBSITE - www.MMHG.org- FOR MORE INFORMATION)					

ANYTHING THAT APPEARS IN BOLD ITALIC TYPE INDICATES A CHANGE IN THE BENEFIT OR WORDING FROM THE PREVIOUS YEAR.

Please note there are no waiting periods, lifetime benefit maximums or pre-existing exclusions for any of the MMHG health insurance plans.

Disclaimer: This comparison summarizes 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. Please call the "member service" phone number on your ID card for specific coverage questions.

Reviewed by Blue Cross Blue Shield of Massachusetts and Harvard Pilgrim Health Care.

Fiscal Year 2024 – 2025

MAYFLOWER MUNICIPAL HEALTH GROUP

PPO COMPARISON OF BENEFITS

Comparison of the following Blue Cross Blue Shield of Massachusetts PPO medical plans:

BLUE CARE ELECT PPO TRADITIONAL
BLUE CARE ELECT VALUE PPO RATE SAVER
BLUE CARE ELECT PREFERRED PPO BENCHMARK

EFFECTIVE 7/1/2024

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield Blue Care Elect (PPO) Options

Effective 7-1-2024

	BLUE CROSS BLUE SHIELD					
	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	None	$250 per member per plan Year $500 per family per plan Year	None	$250 per member per plan Year $500 per family per plan Year	$300 per member per Plan Year $900 per family per Plan Year (Plan year deductible combined for in and out of network services)	$300 per member per Plan Year $900 per family per Plan Year (Plan year deductible combined for in and out of network services)
Out of Pocket (OOP) Maximum-Plan Year	$2,000 per member/$4,000 per family (per plan year) for Medical benefits (Combined in and Out of Network) AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits- OOP maximum is for all services except - premiums, balance-billed charges, and health care this plan doesn't cover.		$2,000 per member/$4,000 per family (per plan year) for Medical benefits (Combined in and Out of Network) AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits- OOP maximum is for all services except - premiums, balance-billed charges, and health care this plan doesn't cover.		$2,000 per member/$4,000 per family (per plan year) for Medical benefits (Combined in and Out of Network) AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits- OOP maximum is for all services except - premiums, balance-billed charges, and health care this plan doesn't cover.	
Eligible Dependents	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status.
Service Area	All 50 States and US Territories	All 50 States and US Territories	All 50 States and US Territories	All 50 States and US Territories	All 50 States and US Territories	All 50 States and US Territories
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
INPATIENT						
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)	Nothing	20% coinsurance after deductible (and amount above allowed charge)	$250 per admission (including maternity care)	20% coinsurance after deductible (and amount above allowed charge)	$500 per admission after deductible -General Hosp $1500 per admission after deductible -higher cost share Hosp. $200 per admission after ded for mental or substance abuse Hosp	20% coinsurance after deductible (and amount above allowed charge)

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield Blue Care Elect (PPO) Options

Effective 7-1-2024

BENEFIT	BLUE CROSS BLUE SHIELD					
	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
INPATIENT cont.						
Physician Services, Surgical Charges, Anesthesia and Consultations	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)
Skilled Nursing Facility	Nothing up to 100 days per plan year at a semi-private room (benefit max combined for services in and out of network).	20% coinsurance after deductible (and amount above the allowed charge)(benefit max combined for services in and out of network).	Nothing up to 100 days per plan year at a semi-private room (benefit max combined for services in and out of network).	20% coinsurance after deductible (and amount above the allowed charge)(benefit max combined for services in and out of network).	Nothing after deductible up to 100 days per plan year at at semi-private room (benefit max combined for services in & out of network)	20% coinsurance after deductible (and amount above the allowed charge)(benefit max combined for services in and out of network).
Rehabilitation Hospital	Nothing to 60 days per plan year benefit maximum (benefit max combined for services in and out of network).	20% coinsurance after deductible(and amount above the allowed charge) (benefit max combined for services in and out of network).	Nothing to 60 days per plan year benefit maximum (benefit max combined for services in and out of network).	20% coinsurance after deductible (and amount above the allowed charge)(benefit max combined for services in and out of network).	Nothing after deductible up to 60 days per plan year benefit maximum (benefit max combined for services in and out of network)	20% coinsurance after deductible(and amount above the allowed charge) (benefit max combined for services in and out of network).
OUTPATIENT HOSPITAL						
Emergency Room Visits for Emergency or Accident Care	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay after deductible (copayment waived if admitted)	$100 copay after deductible (copayment waived if admitted)
OutPatient Surgery	Nothing in surgical facility, hospital or surgical daycare unit	20% coinsurance after deductible (and amount above the allowed charge)	$150 per admission at surgical facility, hospital or day care unit	20% coinsurance after deductible(and amount above the allowed charge)	$250 per admission after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Radiation and Chemotherapy	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible(and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible(and amount above the allowed charge)
Diagnostic X-ray & Lab	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)

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	BLUE CROSS BLUE SHIELD					
	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT CONT.	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
High Tech Radiology (MRI, CT, PT Scans)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	$25 copay per category per date of service (copay waived at free-standing facilities)	20% coinsurance after deductible (and amount above the allowed charge)	$100 copay after deductible (per category test, per date of service)(copay waived at free-standing facilities)	20% coinsurance after deductible (and amount above the allowed charge)
Hemodialysis	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Physical Therapy	$15 copay up to 100 visits per member per plan year combined with Out-Of-Network services.	20% coinsurance after deductible(and amount above the allowed charge) up to 100 visits per member per plan year combined with In-Network services	$20 copay up to 100 visits per member per plan year combined with Out-Of-Network services.	20% coinsurance after deductible (and amount above the allowed charge) up to 100 visits per member per plan year combined with In-Network services	$20 copay up to 60 visits (deductible does not apply) per member per plan year combined with Out of Network Services	20% coinsurance after deductible (and amount above the allowed charge) up to 60 visits per member per plan year combined with In-Network services
PHYSICIAN'S OFFICE						
Office Visit- PCP Medical, Clinic, Mental Health Care, Substance Abuse Care	$15 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 or $60 copay (depending on provider)	20% coinsurance after deductible (and amount above the allowed charge)
Office Visit- Specialist	$15 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 or $60 copay (depending on provider)	20% coinsurance after deductible (and amount above the allowed charge)
Well Child Care Up to Age 19	Nothing 10 visits 1st year 3 visits 2nd year 2 visits for age 2 1 visit per plan year from age 3-18	20% coinsurance after deductible (and amount above the allowed charge) 10 visits 1st year 3 visits 2nd year 2 visits for age 2 1 visit per plan year from age 3-18	Nothing 10 visits 1st year 3 visits 2nd year 2 visits for age 2 1 visit per plan year from age 3-18	20% coinsurance after deductible (and amount above the allowed charge) 10 visits 1st year 3 visits 2nd year 2 visits for age 2 1 visit per plan year from age 3-18	Nothing 10 visits 1st year 3 visits 2nd year 2 visits for age 2 1 visit per plan year from age 3-18	20% coinsurance after deductible (and amount above the allowed charge) 10 visits 1st year 3 visits 2nd year 2 visits for age 2 1 visit per plan year from age 3-18
Adult Routine Physicals Age 19 or over	Nothing - 1 visit per member per plan year	20% coinsurance after deductible (and amount above the allowed charge)	Nothing - 1 visit per member per plan year	20% coinsurance after deductible (and amount above the allowed charge)	Nothing - 1 visit per member per plan year	20% coinsurance after deductible (and amount above the allowed charge)

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BENEFIT	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Routine GYN Exam-1 visit per plan year	Nothing - 1 visit per plan year	20% coinsurance after deductible(and amount above the allowed charge)	Nothing - 1 visit per plan year	20% coinsurance after deductible (and amount above the allowed charge)	Nothing - 1 visit per plan year	20% coinsurance after deductible (and amount above the allowed charge)
Routine Colonoscopy (without surgery)	Nothing	20% coinsurance after deductible (and amount above allowed charge)	Nothing	20% coinsurance after deductible (and amount above allowed charge)	Nothing	20% coinsurance after deductible (and amount above allowed charge)
Routine Mammogram	Nothing -One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.	20% coinsurance after deductible (and amount above allowed charge) - One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.	Nothing -One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.	20% coinsurance after deductible (and amount above allowed charge) - One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.	Nothing -One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.	20% coinsurance after deductible (and amount above allowed charge) - One baseline mammogram during the 5-year period in which the member is age 35 - 39 and one mammogram each plan year from age 40 or older.
Routine Vision Exam	Nothing- 1 visit per member every 12 months	20% coinsurance after deductible(and amount above the allowed charge)	Nothing - 1 visit per member every 24 months	20% coinsurance after deductible (and amount above the allowed charge)	Nothing - 1 visit per member every 24 months	20% coinsurance after deductible (and amount above the allowed charge)
Family Planning Services	Nothing	20% coinsurance after deductible(and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)
OTHER OUTPATIENT						
Visiting Nurse Home Health Care	Nothing	20% coinsurance after deductible(and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Hospice Services	Nothing when arranged and authorized by a plan physician	20% coinsurance after deductible(and amount above the allowed charge)	Nothing when arranged and authorized by a plan physician	20% coinsurance after deductible (and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	$15 copay	20% coinsurance after deductible (and amount above allowed charge)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$60 copay	20% coinsurance after deductible (and amount above the allowed charge)

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BENEFIT	**BLUE CARE ELECT PPO TRADITIONAL**		**BLUE CARE ELECT RATE SAVER**		**BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Durable Medical Equipment	20% (no dollar max) (prosthetics covered in full with no maximum)	40% coinsurance after deductible (prosthetics 20% coinsurance after deductible)(and amount above allowed charge.)	20% coinsurance. Prosthetic devices is 20% Coinsurance. Ostomy supplies No Cost.	40% coinsurance after deductible (prosthetics 40% coinsurance after deductible)	20% coinsurance after deductible (prosthetics 20% coinsurance after deductible)	40% coinsurance after deductible (prosthetics 40% coinsurance after deductible)
Ambulance (when medically necessary)	Nothing	Nothing for accident or emergency; 20% coinsurance after deductible(and amount above the allowed charge) other medically necessary ambulance transport	Nothing	Nothing for accident or emergency; 20% coinsurance after deductible(and amount above the allowed charge) other medically necessary ambulance transport	Nothing after deductible	Nothing after deductible for accident or emergency; 20% coinsurance after deductible(and amount above the allowed charge) for other medically necessary ambulance transport
Dental Care	Not covered except for preventive care for members under 18 to treat cleft lip and cleft palate (no cost)	Not covered except for Preventive dental care for members under 18 to treat cleft lip and cleft palate (20% Coinsurance after deductible. Provider may balance bill)	Not covered - except for preventive care for members under 18 to treat cleft lip and cleft palate (no cost)	Not covered- except for Preventive dental care for members under 18 to treat cleft lip and cleft palate (20% Coinsurance after deductible. Provider may balance bill)	Not covered - except for preventive care for members under 18 to treat cleft lip and cleft palate (no cost)	Not covered- except for Preventive dental care for members under 18 to treat cleft lip and cleft palate (20% Coinsurance after deductible. Provider may balance bill)
Chiropractor Visits	$15 copay per visit	20% coinsurance after deductible(and amount above the allowed charge)	$20 copay per visit	20% coinsurance after deductible (and amount above the allowed charge)	$20 copay per visit (deductible does not apply)	20% coinsurance after deductible (and amount above the allowed charge)
Hearing Aids	Nothing - $2,000 per ear every 36 months (age 21 or under) Benefit limit	20% coinsurance after deductible up to Benefit limit	Nothing - $2,000 per ear every 36 months (age 21 or under) Benefit Limit	20% coinsurance after deductible up to Benefit limit	Nothing - $2,000 per ear every 36 months (age 21 or under) Benefit Limit (Not subject to deductible)	20% coinsurance after deductible up to Benefit limit
Acupuncture	$15 copay per visit - 12 visits per member per plan year (Deductible and/or coinsurance not applicable)		$20 copay per visit - 12 visits per member per plan year (Deductible and/or coinsurance not applicable)		$60 copay per visit - 12 visits per member per plan year (Deductible and/or coinsurance not applicable)	
Telemedicine- Virtual visits on your computer, tablet or smart phone for medical care and behavioral health	$15 Copay per visit with a Well Connection Provider or a Doctor in the BCBSMA Network that provides Telemedicine Services	Not Covered	$20 Copay per vist with a Well Connection Provider or a Doctor within the BCBSMA Network that offers Telemedicine Services	Not Covered	$20 or $60 copay (depending on provider) with a Well Connection Provider or a Doctor within the BCBSMA Network that provides Telemedicine Services	Not Covered
Prescription Drugs- 30-day supply retail pharmacy or 90-day supply mail service/CVS retail locations (See also *CanaRx program for certain brand named prescriptions with no cost share)	Formulary drugs retail: Tier 1: $10 copay Tier 2: $20 copay Tier 3: $35 copay 30-day supply retail pharmacy or 90-day supply mail service/CVS retail locations Non-formulary drugs: all charges	Not Covered	Formulary drugs retail: Tier 1: $10 copay Tier 2: $25 copay Tier 3: $45 copay Mail Order/CVS retail: Tier 1: $20 copay Tier 2: $50 copay Tier 3: $90 copay Non-formulary drugs: all charges	Not Covered	Formulary drugs retail: Tier 1: $10 copay Tier 2: $30 copay Tier 3: $65 copay Mail Order/CVS retail: Tier 1: $25 copay Tier 2: $75 copay Tier 3: $165 copay Non-formulary drugs: all charges	Not Covered

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BENEFIT	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	Benefit	Benefit	Benefit	Benefit	Benefit	Benefit
OTHER BENEFITS						
Fitness Benefit/Special Programs/	ALL PLANS INCLUDE: Up to $300 reimbursement toward membership or exercise classes at a health club or virtual fitness memberships or classes or home fitness equipment. Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees. ***New for 2024 Enhanced Fitness Benefits: •Bicycles/Bicycle Helmets - Bicycles that are purchased for recreational use and bicycle helmets.*** ***•Athletic Shoes- Athletic shoes designed to be worn for sports, exercising, or recreational activity.*** ***•Sports Activity Fees- Sports activity fees including (but not limited to): ski passes, fees for sports leagues (such as town sports, tennis, golf, or basketball), and race participation fees.***					
Mind and Body Reimbursement	ALL PLANS INCLUDE: Up to $300 reimbursement per family per Calendar Year for Holistic Health such as Massage Therapy, Tai Chi, Hypnosis Therapy, Qi (chi) gong, Meditation Therapy and Breathing and meditation apps. You can also receive 30% off standard rates when you use an alternative health practitioner in the BCBSMA Network.					
***CanaRx Prescription Savings Program**	Program eligible for certain Brand Name maintenance prescriptions- visit https://www.canarx.com/plan/?planid=MMHG for details					
SmartShopper Incentive Program	SmartShopper program eligible	Not eligible	SmartShopper program eligible	Not eligible	SmartShopper program eligible	Not eligible
Learn to Live- confidential online cognitive behavioral therapy	Free confidential 24/7 online cognitive behavioral therapy for Worry, Stress, Anxiety, Depresession, Insomnia, Panic, Resilience, Substance Abuse. All employees and their family members (age 13 and over) are eligible. Visit learntolive.com/partners and enter the code MMHG. Take a quick free confidential assessment.					
MMHG Wellness Program	***QUARTERLY NEWSLETTER, WELLNESS SEMINARS/SCREENINGS/WEBINARS/CHALLENGES, INCENTIVE PROGRAMS, ON DEMAND VIRTUAL FITNESS & MINDFULNESS CLASSES/NUTRITION/SLEEP, HEALTHY RESOURCES WEBSITE/INSTAGRAM & MORE*** (PARTICIPATION IN CERTAIN PROGRAMS MAY VARY BY MEMBER UNIT. PLEASE CHECK WITH YOUR BENEFIT COORDINATOR OR WELLNESS COORDINATOR AND OUR WEBSITE - www.MMHG.org- FOR MORE INFORMATION)					

ANYTHING THAT APPEARS IN ITALIC BOLD TYPE INDICATES A CHANGE IN THE BENEFIT OR WORDING FROM THE PREVIOUS YEAR.

Please note there are no waiting periods, lifetime benefit maximums or pre-existing exclusions for any of the MMHG health insurance plans.

Disclaimer: This comparison summarizes 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.

Please call the "member service" phone number on your ID card for specific coverage questions.

Reviewed by Blue Cross Blue Shield of Massachusetts.