Fiscal Year 2024 – 2025

MAYFLOWER MUNICIPAL HEALTH GROUP

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TOWN OF PEMBROKE COMPARISON OF BENEFITS

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Comparison of the following medical plans:

BLUE CARE ELECT VALUE PPO RATE SAVER

BCBSMA NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER

HPHC HMO RATE SAVER

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

Effective 7-1-2024	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE
	BLUE CARE ELECT PPO RATE SAVER		NETWORK BLUE	HPHC HMO RATE SAVER
BENEFIT	**In-Network**	**Out-of-Network**	**NEW ENGLAND (NE) HMO RATE SAVER**	
Deductible	None	$250 per member per plan Year $500 per family per plan Year	None	None
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) $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
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.
Service Area- (check participating providers online)	All 50 States and US Territories	All 50 States and US Territories	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, VT ***(CT no longer in service area effective 1/1/2024)***

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BENEFIT	In-Network	Out-of-Network	NEW ENGLAND (NE) HMO RATE SAVER	
	YOU PAY	YOU PAY	YOU PAY	YOU PAY
INPATIENT				
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)	$250 per admission (including maternity care)	20% coinsurance after deductible (and amount above allowed charge)	$250 per admission (including maternity care)	$250 per admission
Physician Services, Surgical Charges, Anesthesia and Consultations.	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	Nothing
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 member per plan year at a semi-private rate	Nothing up to 100 days per plan year at a semi-private rate for each benefit
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	Covered in full when medically necessary and authorized by a plan physician - up to 60 days per plan year
OUTPATIENT HOSPITAL				
Emergency Room Visits for Emergency or Accident Care	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
OutPatient Surgery	$150 per admission at surgical facility, hospital or day care unit	20% coinsurance after deductible(and amount above the allowed charge)	$150 per admission surgical facility, hospital, or surgical day care unit	$150 per admission
Radiation and Chemotherapy	Nothing	20% coinsurance after deductible(and amount above the allowed charge)	Nothing	Nothing
Diagnostic X-ray & Lab	Nothing	20% coinsurance after deductible(and amount above the allowed charge)	Nothing	Nothing

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	YOU PAY	YOU PAY	YOU PAY	YOU PAY
High Tech Radiology (MRI, CT, PT Scans)	$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 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 procedure (Copay waived at free-standing facilities)
Hemodialysis	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	Nothing
Physical Therapy	$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	$35 copay to 60 visits per member per plan year.	$20 co-pay per visit; 60 visits PT/OT per plan year
PHYSICIAN'S OFFICE				
PCP OV				
Tier 1	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 copay	$20 copay
Tier 2			No tiering	No tiering
Tier 3			No tiering	No tiering
Specialist OV				
Tier 1	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$35 copay	$35 copay
Tier 2			No tiering	No tiering
Tier 3			No tiering	No tiering
Mental Health Care, Substance Abuse Care	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 copay	$20 copay
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	Nothing
Adult Routine Physicals- Age 19 and over	Nothing - 1 visit per member per plan year	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	Nothing
Routine GYN Exam- 1 visit per plan year	Nothing - 1 visit per member per plan year	20% coinsurance after deductible (and amount above the allowed charge)	Nothing - 1 visit per plan year	Nothing

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	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Routine Colonoscopy (without surgery)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	Nothing
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.	Nothing
Routine Vision Exam **Preventative Vision Exam**	Nothing - 1 visit every 24 months	20% coinsurance after deductible (and amount above the allowed charge)	Nothing - 1 visit per member every 12 months	$20 copay (1 visit per plan year)
Family Planning Services	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	Member cost share depends on type of service provided (contraception/counseling covered in full/ Infertility services, $20 copay per visit)
OTHER OUTPATIENT				
Visiting Nurse **Home Health Care**	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	Nothing
Hospice Services	Nothing when arranged and authorized by a plan physician	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	Nothing
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$35 copay	$20 Copay PCP (level1) $35 copay Outpatient-(level 2)
Durable Medical Equipment	20% coinsurance. Prosthetic devices is 20% Coinsurance. Ostomy supplies No Cost.	40% coinsurance after deductible (prosthetics 40% coinsurance after deductible)	20% (no dollar max) (prosthetics at 0% with no maximum)	Covered in Full no benefit limit
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

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	YOU PAY	YOU PAY	YOU PAY	YOU PAY
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 members under 18 to treat cleft lip and cleft palate.	$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
Chiropractor Visits	$20 copay per visit	20% coinsurance after deductible (and amount above the allowed charge)	$35 copay per visit	$20 copay per visit -12 visits per plan year.
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 for members 21 and under Benefit limit	No Charge Limited to $2000 per hearing aid every 36 months for each ear, for members up to age 22
Acupuncture	$20 copay per visit - 12 visits per member per plan year (Deductible and/or coinsurance not applicable)		$35 copay per visit - 12 visits per member per plan year	$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 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: 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	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

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BENEFIT	**In-Network**	**Out-of-Network**	**NEW ENGLAND (NE) HMO RATE SAVER**	
	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	$20 Copay per vist with a Well Connection Provider or a Doctor within the BCBSMA Network that offers Telemedicine Services	Not Covered	$20 or $35 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. $20 Copay for DoD and Level 1 providers/ $35 for Level 2
OTHER BENEFITS	**Benefit**	**Benefit**	**Benefit**	**Benefit**
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 chilbirthing 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			
SmartShopper Incentive Program	SmartShopper program eligible-Shop for high quality providers and get rewarded	Not eligible	SmartShopper program eligible-Shop for high quality providers and get rewarded	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 and Harvard Pilgrim Health Care.