Fiscal Year 2019 – 2020

MAYFLOWER MUNICIPAL HEALTH GROUP

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TOWN OF PEMBROKE COMPARISON OF BENEFITS

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Comparison of the following <u>HMO/PPO</u> medical plans:

BLUE CARE ELECT VALUE PPO RATE SAVER

BCBSMA NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER

HPHC HMO RATE SAVER

FY20 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care Options

Effective 7-1-2019	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE
	BLUE CARE ELECT PPO RATE SAVER		NETWORK BLUE	HPHC
BENEFIT	**In-Network**	**Out-of-Network**	**NEW ENGLAND (NE) HMO RATE SAVER**	**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) 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 $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.	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. 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, CT and VT
	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

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BENEFIT	In-Network	Out-of-Network	NEW ENGLAND (NE) HMO RATE SAVER	HMO RATE SAVER
	YOU PAY	YOU PAY	YOU PAY	YOU PAY
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
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 plan year (copay waived at free-standing facilities)	$100 per date of service (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

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	YOU PAY	YOU PAY	YOU PAY	YOU PAY
PHYSICIAN'S OFFICE				
PCP OV				
Tier 1	$20 copay		$20 copay	$20 copay
Tier 2	No tiering	20% coinsurance after deductible(and amount above the allowed charge)	No tiering	No tiering
Tier 3	No tiering		No tiering	No tiering
Specialist OV				
Tier 1	$20 copay		$35 copay	$35 copay
Tier 2	No tiering		No tiering	No tiering
Tier 3	No tiering		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
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

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	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Routine Vision Exam **Preventative Vision Exam**	Nothing - 1 visit per member every 24 months	20% coinsurance after deductible(and amount above the allowed charge)	Nothing - 1 visit per member every 12 months	$20 copay/no copay for children up to age 5 (1 visit per plan year)
Family Planning Services	Nothing	20% coinsurance after deductible(and amount above the allowed charge)	Nothing	$20 copay
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	Member cost share depends on type of service provided
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	$35 copay
Durable Medical Equipment	20% coinsurance (prosthetics covered in full)	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
Dental Care	Not covered	Not covered	Not covered	$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. **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.

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	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Hearing Aids	Nothing - $2,000 per ear every 36 months for members up to age 22 Benefit limit	20% coinsurance after deductibleup to benefit limit	Nothing - $2,000 per ear every 36 months for members up to age 22 Benefit limit	No Charge Limited to $2000 per hearing aid every 36 months for members up to the age of 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	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	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
Telemedicine - Virtual visits available on your computer, tablet or smart phone for medical care and behavioral health	***$20 Copay per visit with a Well Connection Provider or a Doctor in the BCBSMA Network that provides 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. $20 Copay***
	Benefit	**Benefit**	**Benefit**	**Benefit**
OTHER BENEFITS				
Fitness Benefit/Special Programs - (See Plan for Details)	Up to ***$300*** reimbursement toward membership or exercise classes at a health club. Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs.	Up to ***$300*** reimbursement toward membership or exercise classes at a health club. Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs.	Up to ***$300*** reimbursement toward membership or exercise classes at a health club. Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs.	Up to ***$300*** 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. Free Eyeware at Visionworks and select Sears Opticals with eye exam. Discounts on eyewear, health education and approved nutrition counseling.

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BENEFIT	In-Network	Out-of-Network	NEW ENGLAND (NE) HMO RATE SAVER	HMO RATE SAVER
OTHER BENEFITS CONT.				
Fitness Benefit/Special Programs - (See Plan for Details) CONT.	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.	Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Discounts on eyewear, health education and approved nutrition counseling.
CanaRx Prescription Savings Program- www.MMHGRX.com	Program eligible for certain Brand Name prescriptions- visit www.MMHGRX.com for details		Program eligible for certain Brand Name prescriptions- visit www.MMHGRX.com for details	Program eligible for certain Brand Name prescriptions- visit www.MMHGRX.com for details
SmartShopper Incentive Program	SmartShopper program eligible	Not eligible	SmartShopper program eligible	Not eligible
MMHG Wellness Program	"BENEFICIAL WELLNESS NEWS" QUARTERLY NEWSLETTER, MONTHLY HEALTH LINKS, WELLNESS SEMINARS/SCREENINGS/WEBINARS, INCENTIVE PROGRAMS, FITNESS CENTER DISCOUNTS, WORKPLACE FLU CLINICS, HEALTHY RESOURCES POSTED ON OUR WEBSITE/FACEBOOK/TWITTER/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.