



**Fiscal Year 2025 – 2026**

***MAYFLOWER MUNICIPAL  
HEALTH GROUP***

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**HMO/PPO COMPARISON OF BENEFITS FOR HSA QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS (HDHP)**  
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**TOWN OF SCITUATE**

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

- BCBSMA NEW ENGLAND HMO HDHP**
- BCBSMA BLUE CARE ELECT PPO HDHP**

**BCBSMA=BLUE CROSS BLUE SHIELD OF MASSACHUSETTS  
HPHC=HARVARD PILGRIM HEALTH CARE**

**\*\*EFFECTIVE 7/1/2025\*\***

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## FY26 Mayflower Municipal Health Group Plan Benefit Comparison HSA Qualified High Deductible Health Plans (HDHP)

Effective 07-01-2025

CIF = Covered In Full

BLUE CROSS BLUE SHIELD			
BENEFIT	HMO New England HDHP	BLUE CARE ELECT PPO HDHP	
		In-Network	Out-of-Network
<b>Deductible</b> - Deductible to be satisfied , then Covered in Full, except prescription copays and out-of-network services. Per plan year (July 1 to June 30). <i>Note</i> - the family plan Deductible must be satisfied before the plan begins to pay. <b>See plan document for full details</b>	\$2,000 per Individual plan \$4,000 per Family plan	\$2,000 per Individual plan \$4,000 per Family plan	\$2,000 per Individual plan \$4,000 per Family plan
<b>Out-of-Pocket (OOP) Maximum</b> - Once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for the remainder of plan year.	<b>Medical &amp; Rx Combined:</b> \$5,000 per member \$10,000 per family	<b>Medical &amp; Rx Combined:</b> In and Out of Network Combined \$5,000 Per individual Plan Per Plan Year \$10,000 Per Family Plan Per Plan Year	
<b>Lifetime Benefit Maximum</b>	None	None	None
INPATIENT	YOU PAY	YOU PAY	YOU PAY
<b>General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - Deductible Applies</b>	Deductible then Covered in Full (CIF)	Deductible then Covered in Full (CIF)	Deductible, then 20% coinsurance Provider may balance bill
<b>Physician Services</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance Provider may balance bill
<b>Skilled Nursing Facility</b>	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then CIF - 100 days per calendar year benefit maximum	Deductible then 20% coinsurance to 100 days per calendar year benefit maximum Provider may balance bill
<b>Rehabilitation Hospital</b>	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then CIF - 60 days per calendar year benefit maximum	Deductible then 20% coinsurance to 60 days per calendar year benefit maximum Provider may balance bill

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	HMO New England HDHP	BLUE CARE ELECT PPO HDHP	
		In-Network	Out-of-Network
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY
<b>Emergency Room Visits for Emergency or Accident Care</b>	\$50 Copayment per visit after deductible	\$50 Copayment per visit after deductible	\$50 copayment per visit after In Network deductible
<b>Emergency Room Visits for Medical Care</b>	\$50 Copayment per visit after deductible	\$50 Copayment per visit after deductible	\$50 Copayment per visit after In Network deductible
<b>Surgery</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance Provider may balance bill
<b>Radiation and Chemotherapy</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill
<b>Diagnostic X-ray and Lab</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill
<b>Routine Colonoscopy (without surgery)</b>	\$0 copay	\$0 copay	20% Coinsurance. Provider may balance bill. Deductible does not apply
<b>High Cost Radiology (MRI, CT &amp; PET)</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill
<b>Hemodialysis</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill
<b>Physical Therapy</b>	Deductible then Covered in Full (CIF) - up to 60 visits per calendar year	Deductible then Covered in Full (CIF) - up to 100 visits combined per calendar year	Deductible, then 20% coinsurance - up to 100 visits combined per calendar year. Provider may balance bill.

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		In-Network	Out-of-Network
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY
<b>Surgery</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.
<b>Adult Preventative Exam</b> <i>as defined by the ACA</i>	CIF	CIF	20% coinsurance. Provider may balance bill. Deductible does not apply.
<b>PCP Medical Care/ Mental Health Care/ Substance Abuse Care</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.
<b>Well Child Care</b> <i>as defined by the ACA</i>	CIF	CIF	20% coinsurance. Provider may balance bill. Deductible does not apply.
<b>Routine GYN Exam</b> <i>(As defined by the ACA-one per calendar year, includes preventative lab tests)</i>	CIF	CIF	20% coinsurance. Provider may balance bill. Deductible does not apply.
<b>Routine Mammogram</b> <i>As defined by the ACA</i>	CIF	CIF	20% coinsurance. Provider may balance bill. Deductible does not apply.
<b>Routine Vision Exam</b>	CIF (once every 24 months)	CIF (once every 24 months)	20% coinsurance (once every 24 months). Provider may balance bill.
<b>Specialist Office Visit</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.
<b>OTHER OUTPATIENT</b>	YOU PAY	YOU PAY	YOU PAY
<b>Visiting Nurse Home Health Care Deductible Applies</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.
<b>Durable Medical Equipment</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.
<b>Ambulance Emergency Transport</b>	Deductible then CIF for all Ambulance Services that are Medically Necessary	Deductible then CIF	CIF After In-Network Deductible
<b>Routine Pediatric Dental</b>	Not Covered except for Preventive dental care 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)	For under age 18 members with Cleft Palate or Cleft Lip only. 20% Coinsurance. Provider may Balance Bill.
<b>Chiropractor Visits</b>	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.
<b>Prescription Drugs - IMPORTANT NOTE - Deductible applies, once deductible is met, copays will apply - NOTE- the drugs on the preventative list are not subject to the deductible. The lists are available online at www.mmhg.org</b>	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order or Designated Retail:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order or Designated Retail:</b> (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	<b>Retail:</b> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay  <b>Mail Order:</b> (90 day supply) Not Covered

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BENEFIT	BLUE CARE ELECT PPO HDHP			
OTHER BENEFITS	Benefit			
OTHER BENEFITS	Benefit			
<b>Fitness Benefit/ Special Programs</b>	<p>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. 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.</p> <p>•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.</p>			
<b>Mind and Body Reimbursement</b>	<p>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.</p>			
<b>Telemedicine- Virtual visits available on your computer, tablet or smart phone for medical care and behavioral health</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Deductible then CIF with Well Connection Provider or a provider within the BCBSMA Network that provides Telehealth Services</td> <td style="width: 33%;">Deductible then CIF with Well Connection Provider or a provider within the BCBSMA Network that provides Telehealth Services</td> <td style="width: 33%;">Deductible then 20% Coinsurance with a Well Connection Provider or a provider within the BCBSMA Provider that provides Telehealth Services</td> </tr> </table>	Deductible then CIF with Well Connection Provider or a provider within the BCBSMA Network that provides Telehealth Services	Deductible then CIF with Well Connection Provider or a provider within the BCBSMA Network that provides Telehealth Services	Deductible then 20% Coinsurance with a Well Connection Provider or a provider within the BCBSMA Provider that provides Telehealth Services
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<b>MMHG Wellness Program</b>	<p style="text-align: center;"><b><u>QUARTERLY NEWSLETTER, WELLNESS SEMINARS/SCREENINGS/WEBINARS/CHALLENGES, INCENTIVE PROGRAMS, ON DEMAND VIRTUAL FITNESS &amp; MINDFULNESS CLASSES/NUTRITION/SLEEP, HEALTHY RESOURCES WEBSITE/INSTAGRAM &amp; MORE</u></b></p> <p style="text-align: center;"><b><u>(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)</u></b></p>			
<b><i>ANYTHING THAT APPEARS IN ITALIC BOLD TYPE INDICATES A CHANGE IN THE BENEFIT OR WORDING FROM THE PREVIOUS YEAR.</i></b>				
<p><b>Please note there are no waiting periods, lifetime benefit maximums or pre-existing exclusions for any of the MMHG health insurance plans.</b></p> <p><b><u>Disclaimer:</u></b> This comparison summarizes benefits of the plan(s). The Subscriber Certificate(s) &amp; applicable riders define the terms &amp; conditions of these benefits in greater detail. <u>Should any questions arise, the certificate(s) &amp; riders will govern.</u></p> <p>Please call the "member service" phone number on your ID card for specific coverage questions.</p>				
Reviewed by Blue Cross Blue Shield of Massachusetts.				