

Fiscal Year 2025 – 2026

MAYFLOWER MUNICIPAL HEALTH GROUP

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PPO OVERVIEW OF BENEFITS

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UPPER CAPE COD TECHNICAL SCHOOL

Overview of the following Blue Cross Blue Shield of Massachusetts PPO medical plan

BLUE CARE ELECT PREFERRED PPO BENCHMARK

EFFECTIVE 7/1/2025

FY26 Mayflower Municipal Health Group Plan Benefit Overview
Blue Cross Blue Shield Blue Care Elect (PPO)

Effective 7-1-2025	BLUE CROSS BLUE SHIELD	
	BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	**In-Network**	**Out-of-Network**
Deductible	$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.	
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.
Service Area	All 50 States and US Territories	All 50 States and US Territories
	YOU PAY	**YOU PAY**
INPATIENT		
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)	$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)

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	YOU PAY	**YOU PAY**
INPATIENT cont.		
Physician Services, Surgical Charges, Anesthesia and Consultations	Nothing	20% coinsurance after deductible (and amount above the allowed charge)
Skilled Nursing Facility	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 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	$100 copay after deductible (copayment waived if admitted)	$100 copay after deductible (copayment waived if admitted)
OutPatient Surgery	$250 per admission after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Radiation and Chemotherapy	Nothing after deductible	20% coinsurance after deductible(and amount above the allowed charge)
Diagnostic X-ray & Lab	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)

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OUTPATIENT CONT.	**YOU PAY**	**YOU PAY**
High Tech Radiology (MRI, CT, PT Scans)	$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 after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Physical Therapy	$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	$20 or $60 copay (depending on provider)	20% coinsurance after deductible (and amount above the allowed charge)
Office Visit- Specialist	$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
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)

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PHYSICIAN'S OFFICE	**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)
Routine Colonoscopy (without surgery)	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.
Routine Vision Exam	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)
OTHER OUTPATIENT		
Visiting Nurse Home Health Care	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Hospice Services	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	$60 copay	20% coinsurance after deductible (and amount above the allowed charge)

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	YOU PAY	**YOU PAY**
Durable Medical Equipment	20% coinsurance after deductible (prosthetics 20% coinsurance after deductible)	40% coinsurance after deductible (prosthetics 40% coinsurance after deductible)
Ambulance (when medically necessary)	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)
Chiropractor Visits	$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 (Not subject to deductible)	20% coinsurance after deductible up to Benefit limit
Acupuncture	$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	$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/Pillar RX for certain brand named prescriptions with low/no cost share)	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	**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. •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	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 at no cost- visit https://www.canarx.com/plan/?planid=MMHG**	
****Pillar Rx Program - cost share assistance program***	***This Cost-Share Assistance Program provides financial assistance using coupons from manufacturers of medication to cover most or all of your out-of-pocket costs for eligible medications.***	
SmartShopper Incentive Program	SmartShopper program eligible	Not available out of network
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.