



Fiscal Year 2019 – 2020

***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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**Comparison of the following Blue Cross Blue Shield of Massachusetts and
Harvard Pilgrim Health Care HMO/PPO medical plans:**

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

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

****EFFECTIVE 7/1/2019****

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FY20 Mayflower Municipal Health Group Plan Benefit Comparison HSA Qualified High Deductible Health Plans (HDHP)

Effective 07-01-2019 CIF = Covered In Full		BLUE CROSS BLUE SHIELD		HARVARD PILGRIM HEALTH CARE
BENEFIT	HMO New England HDHP	BLUE CARE ELECT PPO HDHP		HPHC HMO HDHP
		In-Network	Out-of-Network	
Deductible - 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. See plan document for full details	\$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	\$2,000 per Individual plan \$4,000 per Family plan
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for the remainder of plan year.	Medical & Rx Combined: \$5,000 per member \$10,000 per family	Medical & Rx Combined: \$5,000 per member \$10,000 per family	Medical & Rx Combined: \$5,000 per member \$10,000 per family	Medical & Rx Combined: \$5,000 per member \$10,000 per family
Lifetime Benefit Maximum	None	None	None	None
INPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - Deductible Applies	Deductible then Covered in Full (CIF)	Deductible then Covered in Full (CIF)	Deductible, then 20% coinsurance	Deductible then Covered in Full (CIF)
Physician Services	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Skilled Nursing Facility	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	Deductible then CIF - 100 days per calendar year benefit maximum
Rehabilitation Hospital	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	Deductible then CIF - 60 days per calendar year benefit maximum

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		In-Network	Out-of-Network	
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care	\$50 Copayment per visit after deductible	\$50 Copayment per visit after deductible	\$50 copayment per visit after In Network deductible	Deductible then \$50 copay
Emergency Room Visits for Medical Care	\$50 Copayment per visit after deductible	\$50 Copayment per visit after deductible	\$50 Copayment per visit after In Network deductible	Deductible then \$50 copay
Surgery	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Radiation and Chemotherapy	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Diagnostic X-ray and Lab	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Routine Colonoscopy (without surgery)	\$0 copay	\$0 copay	Deductible, then 20% coinsurance	\$0 copay
High Cost Radiology (MRI, CT & PET)	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Hemodialysis	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Physical Therapy	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	Deductible then Covered in Full (CIF) - up to 60 visits per calendar year
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF

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		In-Network	Out-of-Network	
	YOU PAY	YOU PAY	YOU PAY	YOU PAY
PHYSICIAN'S OFFICE				
Adult Preventative Exam <i>as defined by the ACA</i>	CIF	CIF	Deductible, then CIF	CIF
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Well Child Care <i>as defined by the ACA</i>	CIF	CIF	Deductible, then 20% coinsurance	CIF
Routine GYN Exam <i>(As defined by the ACA- one per plan year , includes preventative lab tests)</i>	CIF	CIF	Deductible, then 20% coinsurance	CIF
Routine Mammogram <i>As defined by the ACA</i>	CIF	CIF	Deductible, then 20% coinsurance	CIF
Routine Vision Exam	CIF (once every 24 months)	CIF (once every 24 months)	20% coinsurance (once every 24 months)	CIF (1 visit per year)
Specialist Office Visit	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse Home Health Care Deductible Applies	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Durable Medical Equipment	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Ambulance	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF
Routine Pediatric Dental	All charges	All charges	All charges	Covered in full: Preventive care for children up to age 13. 2 visits per member per plan year including exam, cleaning, x-rays, & flouride treatment.
Chiropractor Visits	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance	Deductible then CIF. (12 visit limit per plan year)

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		In-Network	Out-of-Network	
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	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: (90 day supply) Not Covered Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay
Fitness Benefit	Up to \$300 reimbursement toward membership or exercise classes at a health club. See plan details. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to \$300 per calendar year toward your program fees.	Up to \$300 reimbursement toward membership or exercise classes at a health club. See plan details. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to \$300 per calendar year toward your program fees.	Up to \$300 reimbursement toward membership or exercise classes at a health club. See plan details. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to \$3000 per calendar year toward your program fees.	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.
Telemedicine- Virtual visits available on your computer, tablet or smart phone for medical care and behavioral health	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	Deductible then CIF through Doctor on Demand.
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)			

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.