Fiscal Year 2024 – 2025

MAYFLOWER MUNICIPAL HEALTH GROUP

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

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 7/1/2024****

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FY25 Mayflower Municipal Health Group Plan Benefit Comparison
HSA Qualified High Deductible Health Plans (HDHP)

Effective 07-01-2024 CIF = Covered In Full	BLUE CROSS BLUE SHIELD			HARVARD PILGRIM HEALTH CARE
		BLUE CARE ELECT PPO HDHP		
BENEFIT	**HMO New England HDHP**	**In-Network**	**Out-of-Network**	**HPHC HMO HDHP**
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). *Note* - 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**: In and Out of Network Combined $5,000 Per individual Plan Per Plan Year $10,000 Per Family Plan Per Plan Year		**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 Provider may balance bill	Deductible then Covered in Full (CIF)
Physician Services	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance Provider may balance bill	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 Provider may balance bill	Deductible then CIF - 100 days per plan 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 Provider may balance bill	Deductible then CIF - 60 days per plan year benefit maximum

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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 Provider may balance bill	Deductible then CIF
Radiation and Chemotherapy	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill	Deductible then CIF
Diagnostic X-ray and Lab	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill	Deductible then CIF
Routine Colonoscopy *(without surgery)*	$0 copay	$0 copay	20% Coinsurance. Provider may balance bill. Deductible does not apply	$0 copay
High Cost Radiology (MRI, CT & PET)	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill	Deductible then CIF
Hemodialysis	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill	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. Provider may balance bill.	Deductible then Covered in Full (CIF) - up to 60 visits per plan year

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BENEFIT	**HMO New England HDHP**	**In-Network**	**Out-of-Network**	**HPHC HMO HDHP**
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Surgery	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.	Deductible then CIF
Adult Preventative Exam *as defined by the ACA*	CIF	CIF	20% coinsurance. Provider may balance bill. Deductibe does not apply.	CIF
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.	Deductible then CIF
Well Child Care *as defined by the ACA*	CIF	CIF	20% coinsurance. Provider may balance bill. Deductibe does not apply.	CIF
Routine GYN Exam *(As defined by the ACA- one per **calendar** year , includes preventative lab tests)*	CIF	CIF	20% coinsurance. Provider may balance bill. Deductibe does not apply.	CIF
Routine Mammogram As defined by the ACA	CIF	CIF	20% coinsurance. Provider may balance bill. Deductible does not apply.	CIF
Routine Vision Exam	CIF (once every 24 months)	CIF (once every 24 months)	20% coinsurance (once every 24 months). Provider may balance bill.	CIF (1 visit per plan year)
Specialist Office Visit	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.	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. Provider may balance bill.	Deductible then CIF
Durable Medical Equipment	Deductible then CIF	Deductible then CIF	Deductible, then 20% coinsurance. Provider may balance bill.	Deductible then CIF
Ambulance Emergency Transport	Deductible then CIF for all Ambulance Services that are Medically Necessary	Deductible then CIF	CIF After In-Network Deductible	Deductible then CIF
Routine Pediatric Dental	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.	$20 copayment per visit: 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. Provider may balance bill.	Deductible then CIF (12 visit limit per plan year)
Prescription Drugs - <u>IMPORTANT NOTE</u> - 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 or Designated Retail:** (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 or Designated Retail:** (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	**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

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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
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 or a provider within the HPHC network that provides Telehealth Services
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.