Fiscal Year 2024 – 2025

MAYFLOWER MUNICIPAL HEALTH GROUP

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PPO COMPARISON OF BENEFITS

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

BLUE CARE ELECT PPO TRADITIONAL
BLUE CARE ELECT VALUE PPO RATE SAVER
BLUE CARE ELECT PREFERRED PPO BENCHMARK

EFFECTIVE 7/1/2024

FY25 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield Blue Care Elect (PPO) Options

Effective 7-1-2024	BLUE CROSS BLUE SHIELD					
	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	None	$250 per member per plan Year $500 per family per plan Year	None	$250 per member per plan Year $500 per family per plan Year	$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.		$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 (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.	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.	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	All 50 States and US Territories	All 50 States and US Territories	All 50 States and US Territories	All 50 States and US Territories
	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
INPATIENT						
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)	Nothing	20% coinsurance after deductible (and amount above allowed charge)	$250 per admission (including maternity care)	20% coinsurance after deductible (and amount above allowed charge)	$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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	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
INPATIENT cont.						
Physician Services, Surgical Charges, Anesthesia and Consultations	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)
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 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 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 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 (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 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	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay after deductible (copayment waived if admitted)	$100 copay after deductible (copayment waived if admitted)
OutPatient Surgery	Nothing in surgical facility, hospital or surgical daycare unit	20% coinsurance after deductible (and amount above the allowed charge)	$150 per admission at surgical facility, hospital or day care unit	20% coinsurance after deductible(and amount above the allowed charge)	$250 per admission after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Radiation and Chemotherapy	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible(and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible(and amount above the allowed charge)
Diagnostic X-ray & Lab	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)

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	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT CONT.	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
High Tech Radiology (MRI, CT, PT Scans)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	$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 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	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Physical Therapy	$15 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	$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	$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	$15 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 or $60 copay (depending on provider)	20% coinsurance after deductible (and amount above the allowed charge)
Office Visit- Specialist	$15 copay	20% coinsurance after deductible (and amount above the allowed charge)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$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	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 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)	Nothing - 1 visit per member per plan year	20% coinsurance after deductible (and amount above the allowed charge)	Nothing - 1 visit per member per plan year	20% coinsurance after deductible (and amount above the allowed charge)

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	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	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)	Nothing - 1 visit per plan year	20% coinsurance after deductible (and amount above the allowed charge)	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)	Nothing	20% coinsurance after deductible (and amount above allowed charge)	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.	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.	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 12 months	20% coinsurance after deductible(and amount above the allowed charge)	Nothing - 1 visit per member every 24 months	20% coinsurance after deductible (and amount above the allowed charge)	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)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)
OTHER OUTPATIENT						
Visiting Nurse Home Health Care	Nothing	20% coinsurance after deductible(and amount above the allowed charge)	Nothing	20% coinsurance after deductible (and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Hospice Services	Nothing when arranged and authorized by a plan physician	20% coinsurance after deductible(and amount above the allowed charge)	Nothing when arranged and authorized by a plan physician	20% coinsurance after deductible (and amount above the allowed charge)	Nothing after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	$15 copay	20% coinsurance after deductible (and amount above allowed charge)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$60 copay	20% coinsurance after deductible (and amount above the allowed charge)

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	BLUE CARE ELECT PPO TRADITIONAL		BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Durable Medical Equipment	20% (no dollar max) (prosthetics covered in full with no maximum)	40% coinsurance after deductible (prosthetics 20% coinsurance after deductible)(and amount above allowed charge.)	20% coinsurance. Prosthetic devices is 20% Coinsurance. Ostomy supplies No Cost.	40% coinsurance after deductible (prosthetics 40% coinsurance after deductible)	20% coinsurance after deductible (prosthetics 20% coinsurance after deductible)	40% coinsurance after deductible (prosthetics 40% coinsurance after deductible)
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 for accident or emergency; 20% coinsurance after deductible(and amount above the allowed charge) other medically necessary ambulance transport	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)	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)	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	$15 copay per visit	20% coinsurance after deductible(and amount above the allowed charge)	$20 copay per visit	20% coinsurance after deductible (and amount above the allowed charge)	$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	20% coinsurance after deductible up to Benefit limit	Nothing - $2,000 per ear every 36 months (age 21 or under) Benefit Limit	20% coinsurance after deductible up to Benefit limit	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	$15 copay per visit - 12 visits per member per plan year (Deductible and/or coinsurance not applicable)		$20 copay per visit - 12 visits per member per plan year (Deductible and/or coinsurance not applicable)		$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	$15 Copay per visit with a Well Connection Provider or a Doctor in the BCBSMA Network that provides Telemedicine Services	Not Covered	$20 Copay per vist with a Well Connection Provider or a Doctor within the BCBSMA Network that offers Telemedicine Services	Not Covered	$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 for certain brand named prescriptions with no cost share)**	Formulary drugs retail: Tier 1: $10 copay Tier 2: $20 copay Tier 3: $35 copay 30-day supply retail pharmacy or 90-day supply mail service/CVS retail locations Non-formulary drugs: all charges	Not Covered	Formulary drugs retail: Tier 1: $10 copay Tier 2: $25 copay Tier 3: $45 copay Mail Order/CVS retail: Tier 1: $20 copay Tier 2: $50 copay Tier 3: $90 copay Non-formulary drugs: all charges	Not Covered	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	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Benefit	**Benefit**	**Benefit**	**Benefit**	**Benefit**	**Benefit**
OTHER BENEFITS						
Fitness Benefit/Special Programs/	ALL PLANS INCLUDE: 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.***					
Mind and Body Reimbursement	ALL PLANS INCLUDE: 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- visit https://www.canarx.com/plan/?planid=MMHG for details					
SmartShopper Incentive Program	SmartShopper program eligible	Not eligible	SmartShopper program eligible	Not eligible	SmartShopper program eligible	Not eligible
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.