



MAYFLOWER MUNICIPAL HEALTH GROUP

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**HMO COMPARISON OF BENEFITS FOR ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES**  
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Fiscal Year 2012 – 2013

Comparison of the following HMO medical plans:

**BLUE CROSS BLUE SHIELD NETWORK BLUE HMO RATE SAVER with changes
BLUE CROSS BLUE SHIELD NETWORK BLUE NE HMO DEDUCTIBLE BENCHMARK
HARVARD PILGRIM HEALTH CARE HMO RATE SAVER with changes
HARVARD PILGRIM HEALTH CARE HMO CHOICENET BENCHMARK**

****ACTIVE EMPLOYEES AND
NON-MEDICARE RETIREES
EFFECTIVE 7/1/2012****

****ACTIVE EMPLOYEES AND
NON-MEDICARE RETIREES
EFFECTIVE 7/1/2012****

**FY13 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care (HMO) Options** 3/5/2012

Effective 7-1-2012	BLUE CROSS BLUE SHIELD		HARVARD PILGRIM HEALTH CARE	
	NETWORK BLUE	NETWORK BLUE	HPHC	HPHC
BENEFIT	HMO RATE SAVER w/CHANGES	NE DEDUCTIBLE BENCHMARK PLAN	HMO RATE SAVER w/CHANGES	CHOICENET BENCHMARK
Deductible	None	\$250 per member per Plan Year \$750 per family per Plan Year	None	\$250 per member per Plan Year \$750 per family per Plan Year Tier 1
Plan Year Out of Pocket Maximum	None	\$2,000 per member per Plan Year \$4,000 per family per Plan year Out of Pocket Max limited to deductible, copayments over \$100 and coinsurance excluding prescription drugs	None	\$2,000 per member per Plan Year \$4,000 per family per Plan year Out of pocket max. for all services except prescription drugs
Lifetime Benefit Maximum	None	None	None	None
Eligible Dependents	Dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status.	Dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status.	Dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status.	Dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status.
Waiting Periods/Pre-Existing Condition Exclusion	None	None	None	None
	NETWORK BLUE	NETWORK BLUE	HPHC	HPHC
BENEFIT	HMO RATE SAVER w/CHANGES	NE DEDUCTIBLE BENCHMARK PLAN	HMO RATE SAVER w/CHANGES	CHOICENET BENCHMARK
INPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)	\$250 per admission (including maternity care)	General Hosp: \$300 per admit after deductible Higher Cost share Hosp: \$700 per admit after deductible \$200 per admission after deductible for Mental Hosp or Substance Abuse Hosp.	\$250 per admission	\$300 Tier 1 copay after deductible \$300 Tier 2 copay after deductible \$700 Tier 3 copay after deductible deductible then \$200 per admission for Mental Hospital or Substance Abuse Hospital
Physician Services, Surgical Charges, Anesthesia and Consultations.	Nothing	Nothing	Nothing	Nothing
Skilled Nursing Facility	Nothing up to 100 days per member per calendar year at a semi-private rate	Nothing after deductible up to 100 days per calendar year	Nothing up to 100 days per calendar year at a semi-private rate for each benefit	Tier 1 deductible then 20% coinsurance up to 100 days per plan year
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum	Nothing after deductible up to 60 days per calendar year benefit maximum	Covered in full when medically necessary and authorized by a plan physician - up to 60 days per calendar year	Tier 1 deductible then no charge up to 60 days per plan year

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BENEFIT	NETWORK BLUE	NETWORK BLUE	HPHC	HPHC
	HMO RATE SAVER w/CHANGES	NE DEDUCTIBLE BENCHMARK PLAN	HMO RATE SAVER w/CHANGES	CHOICENET BENCHMARK
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
OUTPATIENT HOSPITAL				
Emergency Room Visits for Emergency or Accident Care	\$100 copay (waived if admitted)	\$100 copay after deductible (waived if admitted)	\$100 copay (waived if admitted)	Deductible then \$100 copay (waived if admitted)
Emergency Room Visits for Medical Care	\$100 copay	\$100 copay after deductible	\$100 copay	Deductible then \$100 copay (waived if admitted)
OutPatient Surgery	\$150 per admission surgical facility, hospital, or surgical day care unit	\$150 after deductible per admission at surgical facility, hospital, or surgical day care unit	\$150 per admission	Deductible then \$150 copay
Radiation and Chemotherapy	Nothing	Nothing after deductible	Nothing	Nothing after deductible
High Tech Radiology (MRI, CT, PT Scans)	\$100 per date of service out of pocket maximum is \$375 per member per calendar year	\$100 per date of service, after deductible	\$100 per date of service	Deductible then \$100 per date of service
Hemodialysis	Nothing	Nothing after deductible	Nothing	Tier 1 Deductible then no charge
Physical Therapy	\$35 copay to 60 visits per member per calendar year.	\$20 copay up to 60 vists per member per calendar year	\$20 co-pay per visit; 30 visits PT, 30 visits OT	\$20 copay per visit 30 visits PT 30 visits OT per plan year
PHYSICIAN'S OFFICE				
PCP OV				
Tier 1	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Tier 2	No tiering	No tiering	No tiering	\$20 copay
Tier 3	No tiering	No tiering	No tiering	\$20 copay
Specialist OV				
Tier 1	\$35 copay	\$35 copay	\$35 copay	\$25 copay
Tier 2	No tiering	No tiering	No tiering	\$35 copay
Tier 3	No tiering	No tiering	No tiering	\$45 copay
Mental Health Care, Substance Abuse Care	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Well Child Care	Nothing	Nothing	Nothing	Nothing
Routine GYN Exam Preventative GYN Exam - \$0 copay	Nothing - 1 visit per calendar year	Nothing - 1 visit per calendar year	Nothing	Nothing

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	NETWORK BLUE	NETWORK BLUE	HPHC	HPHC
BENEFIT	HMO RATE SAVER w/CHANGES	NE DEDUCTIBLE BENCHMARK PLAN	HMO RATE SAVER w/CHANGES	CHOICENET BENCHMARK
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Routine Vision Exam Preventative Vision Exam - \$0 copay	Nothing - 1 visit per member every 12 months	Nothing - 1 visit every 24 months	\$20 copay covered in full for children to age 5	Nothing - 1 visit every 2 Plan years
Adult Routine Physicals Preventative Physicals - \$0 copay	Nothing	Nothing	Nothing	Nothing
Podiatry Benefits - (Routine foot care not covered)	\$20 copay	\$35 copay	\$20 copay when determined medically necessary by plan physician	Specialist copay
Family Planning Services	Nothing	Nothing	\$20 copay per visit	Member cost share depends on type of service provided
OTHER OUTPATIENT				
Visiting Nurse Home Health Care	Nothing	Nothing after deductible	Nothing	Member cost share depends on type of service provided
Hospice Services	Nothing	Nothing after deductible	Member cost share depends on type of service provided	Member cost share depends on type of service provided
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	\$20 copay	\$35 copay	\$35 copay	Deductible then no charge
Durable Medical Equipment	Nothing up to \$1,500 per member per calendar year benefit maximum (prosthetics at 0% with no maximum)	20% after deductible (no dollar max)	Covered in Full limit no benefit	Tier 1 deductible then no charge
Ambulance (when medically necessary)	Nothing	Nothing after deductible	Nothing	Tier 1 deductible then no charge
Dental Care	Not covered	Not covered	\$0 copay preventive care for children under age 12. 2 visits per member per calendar year including exam, cleaning, x-rays, & fluoride treatment. \$35 copay for extraction of unerupted teeth impacted in bone and initial emergency treatment	Tier 1 Primary care copay: \$20 per visit for preventative Dental care for children up to age 13; Other services member cost share will depend upon the types of services provided.

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BENEFIT	NETWORK BLUE	NETWORK BLUE	HPHC	HPHC
	HMO RATE SAVER w/CHANGES	NE DEDUCTIBLE BENCHMARK PLAN	HMO RATE SAVER w/CHANGES	CHOICENET BENCHMARK
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Chiropractor Visits	\$35 copay per visit	\$20 copay per visit	\$20 copay per visit -12 visits per calendar year.	\$20 copay per visit (20 visits per calendar year)
Prescription Drugs	Formulary drugs: Tier 1: \$10 copay Tier 2: \$25 copay Tier 3: \$45 copay Mail order: Tier 1: \$20 copay Tier 2: \$50 copay Tier 3: \$90 copay 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges	Formulary drugs: Tier 1: \$10 copay Tier 2: \$25 copay Tier 3: \$50 copay Mail Order: Tier 1: \$20 copay Tier 2: \$50 copay Tier 3: \$110 copay 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges	Retail: Tier 1: \$10 copay Tier 2: \$25 copay Tier 3: \$45 copay Mail Order: Tier 1: \$20 copay Tier 2: \$50 copay Tier 3: \$90 copay 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges	Retail: Tier 1: \$10 copay Tier 2: \$25 copay Tier 3: \$50 copay Mail order: Tier 1: 20 copay Tier 2: \$50 copay Tier 3: \$110 copay 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges
OTHER BENEFITS				
Fitness Benefit/Special Programs - (See Plan for Details)	Up to \$150 reimbursement toward membership or exercise classes at a health club. 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.	Up to \$150 reimbursement toward membership or exercise classes at a health club. Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs.	Up to \$150 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. Free Eyeware at Cambridge Eye and select Sears Opticals with eye exam. Discounts on eyewear, health education and approved nutrition counseling.	Up to \$150 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. Free Eyeware at Cambridge Eye and select Sears Opticals with eye exam. Discounts on eyewear, health education and approved nutrition counseling.

ANYTHING THAT APPEARS IN ITALIC BOLD TYPE INDICATES A CHANGE IN THE BENEFIT OR WORDING FROM THE PREVIOUS YEAR.

These pages summarize 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.

Reviewed by Carriers.