MAYFLOWER MUNICIPAL HEALTH GROUP

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PPO COMPARISON OF BENEFITS FOR ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES

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Fiscal Year 2013 – 2014

Comparison of the following PPO medical plans:

BLUE CROSS BLUE SHIELD BLUE CARE ELECT VALUE PLUS PPO RATE SAVER
BLUE CROSS BLUE SHIELD BLUE CARE ELECT PREFERRED PPO DEDUCTIBLE BENCHMARK

****ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES EFFECTIVE 7/1/2013****

****ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES EFFECTIVE 7/1/2013****

FY14 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield Blue Care Elect (PPO) Options

Effective 7-1-2013	BLUE CROSS BLUE SHIELD			
	BLUE CARE ELECT RATE SAVER		BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN	
BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	None	$250 per member per Calendar Year $500 per family per Calendar Year	$250 per member per Plan Year $750 per family per Plan Year (Plan year deductible combined for in and out of network services)	$250 per member per Plan Year $750 per family per Plan Year (Plan year deductible combined for in and out of network services)
Calendar/Plan Year Out of Pocket Maximum	None	$1,000 per member per Calendar Year $2,000 per family per Calendar Year	$2,000 per member per Plan Year $4,000 per family per Plan year (Plan Year OOP coinsurance max combined for in and out of network services) Out of Pocket Max limited to deductible, copayments over $100 and coinsurance excluding prescription drugs	$2,000 per member per Plan Year $4,000 per family per Plan year (Plan Year OOP coinsurance max combined for in and out of network services) Out of Pocket Max limited to deductible, copayments over $100 and coinsurance excluding 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
	BLUE CARE ELECT RATE SAVER		**BLUE CARE ELECT DEDUCTIBLE-BENCHMARK PLAN**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
INPATIENT				
General Hospital, Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)	$250 per admission (including maternity care)	20% coinsurance after deductible	$300 per admission General Hosp care $700 per admission higher cost share Hosp. $200 per admission after ded for mental or substance abuse hosp	20% coinsurance after deductible

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BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Physician Services, Surgical Charges, Anesthesia and Consultations.	Nothing	20% coinsurance after deductible	Nothing	20% coinsurance after deductible
Skilled Nursing Facility	Nothing up to 100 days per calendar year at a semi-private room (benefit max combined for services in and out of network).	20% coinsurance after deductible (benefit max combined for services in and out of network).	Nothing up to 100 days per calendar year at at semi-private room (benefit max combined for services in & out of network)	20% coinsurance after deductible (benefit max combined for services in and out of network).
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum (benefit max combined for services in and out of network).	20% coinsurance after deductible (benefit max combined for services in and out of network).	Nothing to 60 days per calendar year benefit maximum (benefit max combined for services in and out of network)	20% coinsurance after deductible (benefit max combined for services in and out of network).
OUTPATIENT HOSPITAL				
Emergency Room Visits for Emergency or Accident Care	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay after deductible (waived if admitted)	$100 copay after deductible (waived if admitted)
Emergency Room Visits for Medical Care	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay after deductible (waived if admitted)	$100 copay after deductible (waived if admitted)
OutPatient Surgery	$150 per admission at surgical facility, hospital or day care unit	20% coinsurance after deductible(and amount above the allowed charge)	$150 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 after deductible	20% coinsurance after deductible(and amount above the allowed charge)
High Tech Radiology (MRI, CT, PT Scans)	$25 copay ***per category*** per date of service	20% coinsurance after deductible(and amount above the allowed charge)	$100 copay after deductible (per category test, per date of service)	20% coinsurance after deductible(and amount above the allowed charge)

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BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Hemodialysis	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	$20 copay up to 100 visits per member per calendar year combined with Out-Of-Network services.	20% coinsurance after deductible (and amount above the allowed charge) up to 100 visits per member per calendar year combined with In-Network services	$20 copay up to 60 visits (deductible does not apply) per member per calendar year combined with Out of Network Services	20% coinsurance after deductible (and amount above the allowed charge) up to 60 visits per member per calendar year combined with In-Network services
PHYSICIAN'S OFFICE				
***Clinic Visits,* Mental Health Care, Substance Abuse Care**	$20 copay	20% coinsurance after deductible(and amount above the allowed charge)	$20 ***or $35 copay (depending on provider)***	20% coinsurance after deductible(and amount above the allowed charge)
Well Child Care	Nothing 10 visits 1st year 3 visits 2nd year 1 visit per year from age 2-18	20% coinsurance after deductible(and amount above the allowed charge) 10 visits 1st year 3 visits 2nd year 1 visit per year from age 2-18	Nothing 10 visits 1st year 3 visits 2nd year 1 visit per year from age 2-18	20% coinsurance after deductible(and amount above the allowed charge) 10 visits 1st year 3 visits 2nd year 1 visit per year from age 2-18
Routine GYN Exam Preventative GYN Exam - $0 copay	Nothing - 1 visit per calendar year	20% coinsurance after deductible (and amount above the allowed charge)	Nothing - 1 visit per calendar year	20% coinsurance after deductible (and amount above the allowed charge)
Routine Vision Exam	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)
Adult Routine Physicals	Nothing - 1 visit per member per calendar year Age 19 or older	20% coinsurance after deductible (and amount above the allowed charge) Age 19 or older	Nothing - 1 visit per member per calendar year Age 19 or older	20% coinsurance after deductible (and amount above the allowed charge) Age 19 or older

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BENEFIT	BLUE CROSS BLUE SHIELD			
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	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Podiatry Benefits - (Routine foot care not covered)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$35 copay	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)
OTHER OUTPATIENT				
Visiting Nurse Home Health Care	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 after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$35 copay	20% coinsurance after deductible (and amount above the allowed charge)
Durable Medical Equipment	20% coinsurance (prosthetics 20% coinsurance)	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 other medically necessary ambulance transport	Nothing after deductible	Nothing after deductible for accident or emergency; 20% coinsurance after deductible for other medically necessary ambulance transport
Dental Care	Not covered	Not covered	Not covered	Not covered
Chiropractor Visits	$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)

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BENEFIT	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
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	Not Covered Not Covered	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 Non-formulary drugs: all charges	Not Covered Not Covered
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. 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. 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. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.

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.