Fiscal Year 2021 – 2022

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 VALUE PPO RATE SAVER

BLUE CARE ELECT PREFERRED PPO BENCHMARK

EFFECTIVE 7/1/2021

FY22 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield Blue Care Elect (PPO) Options

Effective 7-1-2021	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 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.	
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.
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
YOU	**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 (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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BENEFIT	In-Network	Out-of-Network	In-Network	Out-of-Network
YOU	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)
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 ***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 ***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	$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	$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 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 after deductible	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
OUTPATIENT CONT.	YOU PAY	YOU PAY	YOU PAY	YOU PAY
High Tech Radiology (MRI, CT, PT Scans)	$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 after deductible	20% coinsurance after deductible (and amount above the allowed charge)
Physical Therapy	$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	$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	$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
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)

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BENEFIT	In-Network	Out-of-Network	In-Network	Out-of-Network
PHYSICIAN'S OFFICE	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)
Routine Colonoscopy (without surgery)	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.
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)
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)

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BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
YOU	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	$20 copay	20% coinsurance after deductible (and amount above the allowed charge)	$60 copay	20% coinsurance after deductible (and amount above the allowed charge)
Durable Medical Equipment	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 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)***
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)
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 (Not subject to deductible)	20% coinsurance after deductible up to Benefit limit
Acupuncture	$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	$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	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**
Ben	**Benefit**	**Benefit**	**Benefit**	**Benefit**
OTHER BENEFITS				
Fitness Benefit/Special Programs/ *Identity Theft* Protection- (See Plan for Details)	**ALL PLANS INCLUDE:** Up to $300 reimbursement toward membership or exercise classes at a health club ***or virtual fitness memberships or classes.*** Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs. ***Member Identity theft protection services (must enroll yearly).*** Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.			
CanaRx Prescription Savings Program- www.MMHGRX.com	Program eligible for certain Brand Name maintenance prescriptions- visit www.MMHGRX.com for details		Program eligible for certain Brand Name maintenance prescriptions- visit www.MMHGRX.com for details	
SmartShopper Incentive Program	SmartShopper program eligible	Not eligible	SmartShopper program eligible	Not eligible
Learn to Live- confidential online cognitive behavioral therapy	Free confidential 24/7 online support for Stress, Depression, Anxiety Social Anxiety, Insomnia and Substance use. All employees and their family members (age 13 and over) are eligible			
MMHG Wellness Program ***MMHG SMART CONSUMER PROGRAM FLYER***	***QUARTERLY NEWSLETTER, MONTHLY HEALTH LINKS, WELLNESS SEMINARS/SCREENINGS/WEBINARS, INCENTIVE PROGRAMS, CHALLENGES, ONLINE FITNESS CLASSES/FITNESS CENTER DISCOUNTS, 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)			

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. ***Smart Consumer Programs are subject to change based on availability/budget.***
Please call the "member service" phone number on your ID card for specific coverage questions.

Reviewed by Blue Cross Blue Shield of Massachusetts.