Fiscal Year 2018 – 2019

MAYFLOWER MUNICIPAL HEALTH GROUP

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HMO COMPARISON OF BENEFITS

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Comparison of the following HMO medical plans:

BCBSMA NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER

BCBSMA NETWORK BLUE NE HMO BENCHMARK

HPHC HMO RATE SAVER

HPHC HMO CHOICENET BENCHMARK

FY19 Mayflower Municipal Health Group Plan Benefit Comparison
Blue Cross Blue Shield and Harvard Pilgrim Health Care (HMO) Options

Effective 7-1-2018	BLUE CROSS BLUE SHIELD		HARVARD PILGRIM HEALTH CARE	
BENEFIT	**NETWORK BLUE NEW ENGLAND (NE) HMO RATE SAVER**	**NETWORK BLUE NE DEDUCTIBLE HMO BENCHMARK PLAN**	**HPHC HMO RATE SAVER**	**HPHC CHOICENET HMO BENCHMARK**
Deductible	None	$300 per member per Plan Year $900 per family per Plan Year	None	$300 per member per Plan Year $900 per family per Plan Year
Maximum Out of Pocket (MOOP)-Plan Year	$2,000 per member/$4,000 per family (per plan year) for Medical benefits AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits MOOP 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 AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits MOOP 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 AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits Out of pocket max. for all services	$2,000 per member/$4,000 per family (per plan year) for Medical benefits AND $3,000 per member/$6,000 per family (per plan year) for prescription drug benefits Out of pocket max. for all services
Eligible Dependents	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.	Dependents up through the month dependent turns age 26, regardless of the dependent's financial dependency, student status, or employment status. Must use in-network providers for most services except emergency.
Service Area- (check participating providers online)	Service area includes the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine. Based on where selected PCP is located.	Service area includes the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine. Based on where selected PCP is located.	MA, NH, ME, RI, CT and VT	MA, NH, ME, RI, CT and VT

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	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)	General Hosp: $500 per admit after deductible Higher Cost share Hosp: $1,500 per admit after deductible $200 per admission after deductible for Mental Hosp or Substance Abuse Hosp.	$250 per admission	$500 Tier 1 copay after deductible $500 Tier 2 copay after deductible $1,500 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 plan year at a semi-private rate	Nothing after deductible up to 100 days per plan year	Nothing up to 100 days per plan year at a semi-private rate for each benefit	Deductible then 20% coinsurance up to 100 days per plan year
Rehabilitation Hospital	Nothing to 60 days per plan year benefit maximum	Nothing after deductible up to 60 days per plan year benefit maximum	Covered in full when medically necessary and authorized by a plan physician - up to 60 days per plan year	Deductible then no charge up to 60 days per plan year
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)
OutPatient Surgery	$150 per admission surgical facility, hospital, or surgical day care unit	$250 after deductible per admission at surgical facility, hospital, or surgical day care unit	$150 per admission	Deductible then $250 copay
Radiation and Chemotherapy	Nothing	Nothing after deductible	Nothing	Deductible then no charge
Diagnostic X-ray & Lab	Nothing	Nothing after deductible	Nothing	Deductible then no charge

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High Tech Radiology (MRI, CT, PT Scans)	$100 per category per date of service out of pocket maximum is $375 per member per plan year (copay waived at free-standing facilities)	$100 copayment per category per date of service after deductible ($375 maximum copayment amount per member per plan year)(copay waived at free-standing facilities)	$100 per date of service (Copay waived at free-standing facilities)	Deductible then $100 per date of service (Copay waived at free-standing facilities)
Hemodialysis	Nothing	Nothing after deductible	Nothing	Deductible then no charge
Physical Therapy	$35 copay to 60 visits per member per plan year.	$20 copay up to 60 vists per member per plan year	$20 co-pay per visit; 60 visits PT/OT per plan year	$20 copay per visit 60 visits PT/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	$60 copay	$35 copay	$60 copay
Tier 2	No tiering	No tiering	No tiering	$60 copay
Tier 3	No tiering	No tiering	No tiering	$60 copay
Mental Health Care, Substance Abuse Care	$20 copay	$20 copay	$20 copay	$20 copay
Well Child Care- up to Age 19	Nothing	Nothing	Nothing	Nothing
Adult Routine Physicals- Age 19 and over	Nothing	Nothing	Nothing	Nothing
Routine GYN Exam- 1 visit per calendar year	Nothing - 1 visit per plan year	Nothing - 1 visit per plan year	Nothing	Nothing
Routine Colonoscopy (without surgery)	Nothing	Nothing	Nothing	Nothing

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	YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
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.	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.	Nothing	Nothing
Routine Vision Exam Preventative Vision Exam	Nothing - 1 visit per member every 12 months	Nothing - 1 visit every 24 months	$20 copay/no copay for children up to age 5 (1 visit per plan year)	Nothing - 1 visit every 2 Plan years
Family Planning Services	Nothing	Nothing	$20 copay	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 and the tier placement of the provider rendering services
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)	$35 copay	***$60*** copay	$35 copay	Deductible then no charge
Durable Medical Equipment	20% (no dollar max)(prosthetics at 0% with no maximum)	20% after deductible (no dollar max)	Covered in Full no benefit limit	Deductible then no charge (no benefit limit)
Ambulance (when medically necessary)	Nothing	Nothing after deductible	Nothing	Deductible then no charge

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Dental Care	Not covered	Not covered	$0 copay preventive care for children up to age 13; 2 visits per plan year including exam, cleaning, x-rays, & fluoride treatment; $35 copay for extraction of unerupted teeth impacted in bone ***in an office setting*** and initial emergency treatment. **THIS IS A PEDIATRIC DENTAL RIDER AND COVERAGE IS LIMITED SEE SUMMARY FOR DETAILS**	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. **THIS IS A PEDIATRIC DENTAL RIDER AND COVERAGE IS LIMITED SEE SUMMARY FOR DETAILS**
Chiropractor Visits	$35 copay per visit	$20 copay per visit	$20 copay per visit -12 visits per plan year.	$20 copay per visit (20 visits per plan year)
Hearing Aids	Nothing - $2,000 per ear every 36 months for members up to age 22 Benefit limit	Nothing - $2,000 per ear every 36 months for members up to age 22 Benefit limit (Not subject to deductible)	No Charge Limited to $2000 per hearing aid every 36 months for members up to the age of 22	No Charge Limited to $1,500 every 2 plan years. No age restriction applies
Acupuncture	$35 copay per visit - 12 visits per member per plan year	***$60*** copay per visit - 12 visits per member per plan year (Deductible and or coinsurance not applicable)	$20 copay 12 visits per plan year at Participating providers	$20 copay 12 visits per plan year at Participating providers
Prescription Drugs	Formulary drugs: Tier 1: $10 copay Tier 2: $25 copay Tier 3: $45 copay Mail Order/***CVS***: Tier 1: $20 copay Tier 2: $50 copay Tier 3: $90 copay 30-day supply retail pharmacy or 90-day supply mail service/***CVS retail locations*** Non-formulary drugs: all charges	Formulary drugs: Tier 1: $10 copay Tier 2: $30 copay Tier 3: $65 copay Mail Order/***CVS***: Tier 1: $25 copay Tier 2: $75 copay Tier 3: $165 copay 30-day supply retail pharmacy or 90-day supply mail service/***CVS retail locations*** 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: $30 copay Tier 3: $65 copay Mail order: Tier 1: $25 copay Tier 2: $75 copay Tier 3: $165 copay 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges

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	Benefit	**Benefit**	**Benefit**	**Benefit**
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 $300 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 $300 per calendar year toward your program fees.	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 Visionworks and select Sears Opticals with eye exam. Discounts on eyewear, health education and approved nutrition counseling.	Up to $300 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 Visionworks and select Sears Opticals with eye exam. Discounts on eyewear, health education and approved nutrition counseling.
MMHGRX.COM/CanaRx Prescription Savings Program	***Program eligible for Brand Name prescriptions-visit www.MMHGRX.com for details***	***Program eligible for Brand Name prescriptions-visit www.MMHGRX.com for details***	***Program eligible for Brand Name prescriptions-visit www.MMHGRX.com for details***	***Program eligible for Brand Name prescriptions-visit www.MMHGRX.com for details***
SmartShopper Incentive Program-click for link	***SmartShopper program eligible***	***SmartShopper program eligible***	***Not eligible***	***Not eligible***
MMHG Wellness Program	"BENEFICIAL WELLNESS NEWS" QUARTERLY NEWSLETTER, MONTHLY HEALTH LINKS, WELLNESS SEMINARS/SCREENINGS, INCENTIVE PROGRAMS, FITNESS CENTER DISCOUNTS, WORKPLACE FLU CLINICS, 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. 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.