

MA BAY HEALTH CARE TRUST
BENEFIT COMPARISON - effective 7/1/24-6/30/25

BENEFIT	BCBS Network Blue NE		BCBS Blue Choice Plan 2		BCBS Blue Care Elect Preferred		BCBS Saver	
	HMO		POS		PPO		PPO	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Monthly Premium Rates (includes MMHG administrative fee)								
Individual	\$994.63	\$1,090.78		\$2,211.45		\$611.00		
EE + 1	\$2044.88	\$2,295.17		\$4,982.28		\$1,454.28		
Family	\$2,666.80	\$2,921.21		\$5,885.58		\$2,005.58		
Calendar Year Deductible	None	None	\$250	None	\$250	\$4,000	\$4,000	
Individual	None	None	\$500	None	\$500	\$8,000	\$8,000	
Family	None	None	\$500	None	\$500	\$8,000	\$8,000	
Out-of-Pocket Maximum	Effective July 1, 2015, prescription co-pays will count towards In-Network Out-of-Pocket Maximums per ACA							
Individual	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$6,850	\$6,850	
Family	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$13,700	\$13,700	
Lifetime Maximum	None	None	None	None	None	None	None	
Individual	None	None	None	None	None	None	None	
Family	None	None	None	None	None	None	None	
Hospital Services - Inpatient								
Hospital Admission	\$250 copay - max of 4 copays per member per year	\$250 copay - max of 4 copays per member per year	20% coinsurance after deductible	\$250 copay - max of 4 copays per member per year	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
Rehabilitation Hospital	No copay	No copay	20% coinsurance after deductible	No copay	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
Benefit Limits	Up to 60 days per calendar year	Up to 60 days per calendar year combined in and out of network	Up to 60 days per calendar year combined in and out of network	Up to 60 days per calendar year combined in and out of network	Up to 60 days per calendar year combined in and out of network	Up to 60 days per calendar year combined in and out of network	Up to 60 days per calendar year combined in and out of network	
Skilled Nursing Facility	No Copay	No copay	20% coinsurance after deductible	No copay	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
Benefit Limits	Up to 100 days per calendar year	Up to 100 days per calendar year combined in and out of network	Up to 100 days per calendar year combined in and out of network	Up to 100 days per calendar year	Up to 100 days per calendar year combined in and out of network	Up to 100 days per calendar year combined in and out of network	Up to 100 days per calendar year combined in and out of network	
BENEFIT	BCBS Network Blue NE		BCBS Blue Choice Plan 2		BCBS Blue Care Elect		BCBS Blue Care Elect	
	HMO		POS		PPO		PPO	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Hospital Services - Outpatient								
Outpatient Surgery	No copay in ambulatory facility, hospital; \$20 per visit in office setting	No copay in ambulatory facility, hospital; \$20 per visit in office setting	20% coinsurance after deductible	No copay in ambulatory facility, hospital; \$20 per visit in office setting	20% coinsurance after deductible other	\$0 After Deductible	20% coinsurance after deductible	
Emergency Room	\$100 copay waived if admitted	\$100 copay waived if admitted	\$100 copay waived if admitted	\$100 copay waived if admitted	\$100 copay waived if admitted	\$0 After Deductible	\$0 After Deductible	
Ambulance Service	No copay	No copay	No copay for accident or emergency; 20% coinsurance after deductible other	No copay	No copay for accident or emergency; 20% coinsurance after deductible other	\$0 After Deductible	\$0 After Deductible	
Diagnostic X-Ray and Lab Service	No cost	No cost	20% coinsurance after deductible	No cost	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
HTR: MRI, CT scan, PET scan, and nuclear cardiac imaging tests	\$50 copay for, waived if received at a free-standing facility	\$50 copay for, waived if received at a free-standing facility	20% coinsurance after deductible	\$50 copay, waived if received at a free-standing facility	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
Primary Care Physician Office Preventative Visit Copay	No copay	No copay	Not covered for adults. Well-child Care(thru age 5): 20% coinsurance after deductible	No copay	20% coinsurance after deductible	No copay	20% coinsurance after deductible	
Annual Visit Limits	1 Exam per member per calendar year ; Well-child care according to age-based schedule (thru age 18)	1 Exam per member per calendar year ; Well-child care according to age-based schedule (thru age 18)	1 Exam per member per calendar year ; Well-child care according to age-based schedule (thru age 18)	1 Exam per member per calendar year ; Well-child care according to age-based schedule (thru age 18)	1 Exam per member per calendar year ; Well-child care according to age-based schedule (thru age 18)	1 Exam per member per calendar year ; Well-child care according to age-based schedule (thru age 18)	1 Exam per member per calendar year ; Well-child care according to age-based schedule (thru age 18)	
Primary Care Physician Office Medical Visit Copay	\$20 copay	\$20 copay	20% coinsurance after deductible	\$20 copay	20% coinsurance after deductible	\$25 Copay After Deductible	20% coinsurance after deductible	
Specialist Care Physician Office Visit Copay	\$20 copay	\$20 copay	20% coinsurance after deductible	\$20 copay	20% coinsurance after deductible	\$40 Copay After Deductible	20% coinsurance after deductible	
Services provided in a Retail Clinic - Outpatient Visit	\$20 copay	\$20 copay	20% coinsurance after deductible	\$20 copay	20% coinsurance after deductible	\$40 Copay After Deductible	20% coinsurance after deductible	
Physical Therapy	\$20 copay	\$20 copay	20% coinsurance after deductible	\$20 copay	20% coinsurance after deductible	\$40 Copay After Deductible	20% coinsurance after deductible	
Annual Visit Limits	Up to 60 days per calendar year (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	
Occupational Therapy	\$20 copay	\$20 copay	20% coinsurance after deductible	\$20 copay	20% coinsurance after deductible	\$40 Copay After Deductible	20% coinsurance after deductible	
Annual Visit Limits	Up to 60 days per calendar year (combined with physical therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with physical therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with physical therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)	
BENEFIT	BCBS Network Blue NE		BCBS Blue Choice Plan 2		BCBS Blue Care Elect		BCBS Blue Care Elect Saver	
	HMO		POS		PPO		PPO	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Hospital Services - Outpatient (continued)								
Chiropractic Office Visit	\$20 copay	Not covered	20% coinsurance after deductible	\$20 copay	20% coinsurance after deductible	\$40 Copay After Deductible	20% coinsurance after deductible	
Annual Visit Limits								
Acupuncture Office Visit (new 7/1/20)	\$20 copay	\$20 copay	20% coinsurance after deductible	\$20 copay	20% coinsurance after deductible	\$40 Copay After Deductible	20% coinsurance after deductible	
Annual Visit Limits	Up to 12 Visits per Calendar Year.	Up to 12 Visits Per Calendar Year		Up to 12 Visits Per Calendar Year		Up to 12 Visits Per Calendar Year		
Mental Health Services								
In-patient treatment	\$250 copay - max of 4 copays per member per year	\$250 copay - max of 4 copays per member per year	20% coinsurance after deductible	\$250 copay - max of 4 copays per member per year	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
Annual Visit Limits	None	None	None	None	None	None	None	
Out-patient treatment	\$20 copay	\$20 copay	20% coinsurance after deductible	\$20 copay	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
Annual Visit Limits	None	None	None	None	None	None	None	
Pharmacy Services								
Retail Copay (up to 30 day supply)	Formulary Only	In Network Pharmacy Only / Formulary Only		In Network Pharmacy Only / Formulary Only				
Tier 1	\$10	\$10	\$10	\$10	\$10	\$10 After Deductible	\$20 After Deductible	
Tier 2	\$25	\$25	\$25	\$25	\$25	\$25 After Deductible	\$50 After Deductible	
Tier 3	\$45	\$45	\$45	\$45	\$45	\$45 After Deductible	\$90 After Deductible	
Mail order Copay (up to 90 day supply)	Formulary Only	In Network Pharmacy Only / Formulary Only		In Network Pharmacy Only / Formulary Only		In Network Pharmacy Only / Formulary Only		
Tier 1	\$20	\$20	\$20	\$20	\$20	\$20 After Deductible	\$20 After Deductible	
Tier 2	\$50	\$50	\$50	\$50	\$50	\$50 After Deductible	\$50 After Deductible	
Tier 3	\$90	\$90	\$90	\$90	\$90	\$135 After Deductible	\$135 After Deductible	
Smart90 (new 7/1/20)	90-day supply of certain meds through CVS Pharmacy at Mail Order Copays	90-day supply of certain meds through CVS Pharmacy at Mail Order Copays		90-day supply of certain meds through CVS Pharmacy at Mail Order Copays		90-day supply of certain meds through CVS Pharmacy at Mail Order Copays		
Vision Care								
Vision Exam - Preventative	\$0 copay	\$0 copay	Not covered	\$0 copay	20% coins. after deductible	\$0 copay	20% coinsurance after deductible	
Frequency	One visit every 24 months	One per calendar year	Not covered	One Exam every 24 months		One Exam every 24 months		

Coverage for reproductive services (including birth control and abortion services)	Yes (No benefits for Voluntary Termination of Pregnancy)	Yes (No benefits for Voluntary Termination of Pregnancy)		Yes (No benefits for Voluntary Termination of Pregnancy)		Yes (No benefits for Voluntary Termination of Pregnancy)	
Hearing Aid Benefit	\$2,000 Per Ear every 36 months (all ages)	\$2,000 Per Ear every 36 months (all ages)	20% coinsurance after deductible all charges beyond maximum	\$2,000 Per Ear every 36 months (all ages)	20% coinsurance after deductible all charges beyond maximum	\$2,000 Per Ear every 36 months (all ages)	20% coinsurance after deductible and all charges over max
Fitness Benefit	\$150 reimbursement gym	\$150 reimbursement gym	\$150 reimbursement gym	\$150 reimbursement gym	\$150 reimbursement gym	\$150 reimbursement gym	\$150 reimbursement gym
Weight Loss Program	\$150 reimbursement per year, per individual/family	\$150 reimbursement per year, per individual/family	\$150 reimbursement per year, per individual/family	\$150 reimbursement per year, per individual/family	\$150 reimbursement per year, per individual/family	\$150 reimbursement per year, per individual/family	\$150 reimbursement per year, per individual/family

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.

Note - Effective July 1, 2012: Extended coverage for adult dependents of an individual covered under the plan up to the age of 26 regardless of their tax filing status, marital status, employment status, or financial dependency on their parent.