

**MA BAY HEALTH CARE TRUST**  
**BENEFIT COMPARISON - effective 7/1/25-6/30/26**

BENEFIT	BCBS Network Blue NE		BCBS Blue Choice Plan 2		BCBS Blue Care Elect Saver	
	HMO		POS		PPO	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network	
<b>Monthly Premium Rates (includes MMHG administrative fee)</b>						
Individual	\$1,044.11	\$1,166.78		\$641.30		
EE + 1	\$2,146.87	\$2,455.48		\$1,526.74		
Family	\$2,799.89	\$3,125.34		\$2,105.61		
<b>Calendar Year Deductible</b>						
Individual	None	None	\$250	\$4,000		
Family			\$500	\$8,000		
<b>Out-of-Pocket Maximum</b>						
<i>Effective July 1, 2015, prescription co-pays will count towards In-Network Out-of-Pocket Maximums per ACA</i>						
Individual	\$2,000	\$2,000		\$6,850		
Family	\$4,000	\$4,000		\$13,700		
<b>Lifetime Maximum</b>						
Individual	None	None		None		
Family						
<b>Hospital Services - Inpatient</b>						
<b>Hospital Admission</b>	\$250 copay - max of 4 copays per member per year	\$250 copay - max of 4 copays per member per year	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
<b>Rehabilitation Hospital</b>	No copay	No copay	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
<b>Benefit Limits</b>	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		
<b>Skilled Nursing Facility</b>	No Copay	No copay	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible	
<b>Benefit Limits</b>	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		
<b>Hospital Services - Outpatient</b>						
<b>Outpatient Surgery</b>	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	\$0 After Deductible	20% coinsurance after deductible	
<b>Emergency Room</b>	\$100 copay waived if admitted	\$100 copay waived if admitted		\$100 copay waived if admitted		
<b>Ambulance Service</b>	No copay	No copay	No copay for accident or emergency; 20% coinsurance after deductible other	\$0 After Deductible		
<b>Diagnostic X-Ray and Lab Service</b>	No cost	No cost	20% coinsurance after deductible	\$0 after deductible	20% coinsurance after deductible	
<b>HTR: MRI, CT scan, PET scan, and nuclear cardiac imaging tests</b>	\$50 copay, waived if received at a free-standing facility	\$50 copay, waived if received at a free-standing facility	20% coinsurance after deductible	\$0 after deductible	20% coinsurance after deductible	
<b>Primary Care Physician Office Preventative Visit Copay</b>	No copay	No copay	Not covered for adults. Well- child Care (thru age 5); 20% coinsurance after deductible	No copay	20% coinsurance after deductible	
<b>Annual Visit Limits</b>	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)		
<b>Primary Care Physician Office Medical Visit Copay</b>	\$20 copay	\$20 copay	20% coinsurance after deductible	\$25 copay after deductible	20% coinsurance after deductible	
<b>Specialist Care Physician Office Visit Copay</b>	\$20 copay	\$20 copay	20% coinsurance after deductible	\$40 copay after deductible	20% coinsurance after deductible	
<b>Services provided in a Retail Clinic - Outpatient Visit</b>	\$20 copay	\$20 copay	20% coinsurance after deductible	\$40 copay after deductible	20% coinsurance after deductible	

<b>Physical Therapy</b>	\$20 copay	\$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)	
<b>Occupational Therapy</b>	\$20 copay	\$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)	
<b>Chiropractic Office Visit</b>	\$20 copay	Not covered	20% coinsurance after deductible	\$40 copay after deductible	20% coinsurance after deductible
Annual Visit Limits					
<b>Acupuncture Office Visit (new 7/1/20)</b>	\$20 copay	\$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	
<b>Mental Health Services</b>					
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	\$0 after deductible	20% coinsurance after deductible
Annual Visit Limits	None	None		None	
Out-patient treatment	\$20 copay	\$20 copay	20% coinsurance after deductible	\$0 After Deductible	20% coinsurance after deductible
Annual Visit Limits	None	None		None	
<b>Pharmacy Services</b>					
Retail Copay (up to 30 day supply)	Formulary Only	In Network Pharmacy Only / Formulary Only			
Tier 1	\$10	\$10		\$10 After Deductible	\$20 After Deductible
Tier 2	\$25	\$25		\$25 After Deductible	\$50 After Deductible
Tier 3	\$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	
Tier 1	\$20	\$20		\$20 After Deductible	
Tier 2	\$50	\$50		\$50 After Deductible	
Tier 3	\$90	\$90		\$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	
<b>Vision Care</b>					
Vision Exam - Preventative	\$0 copay	\$0 copay	Not covered	\$0 copay	20% coinsurance after deductible
Frequency	One exam every 24 months	One exam per calendar year	Not covered	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)	
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 and all charges over max
Fitness Benefit	\$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	

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.