MA BAY HEALTH CARE TRUST
BENEFIT COMPARISON - effective 7/1/26-6/30/27

BENEFIT	BCBS Network Blue NE	BCBS Blue Choice Plan 2		BCBS Blue Care Elect Preferred		BCBS Saver	
	HMO	POS		PPO		PPO	
	In-Network Only	PCP / Plan Approved	Self - Referred	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium Rates (includes MMHG administrative fee)							
Individual	**$1,199.98**	**$1,399.14**		**$2,838.08**		**$736.75**	
EE + 1	**$2,468.15**	**$2,945.58**		**$6,395.83**		**$1,755.00**	
Family	**$3,219.12**	**$3,749.41**		**$7,555.66**		**$2,420.70**	
Calendar Year Deductible Individual	None	None	$250	None	$250	$4,000	$4,000
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 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	$100 copay	$100 copay	$100 copay	$100 copay	$0 After Deductible	$0 After Deductible
	waived if admitted	waived if admitted	waived if admitted	waived if admitted	waived if admitted	waived if admitted	waived if admitted
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)	20% coinsurance after deductible	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) ** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome
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)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with physical therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with physical therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy visits)** No limit for treatment of Down Syndrome

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	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 After Deductible	$20 After Deductible
Tier 2	$25	$25		$25		$25 After Deductible	$50 After Deductible
Tier 3	$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 After Deductible	
Tier 2	$50	$50		$50		$50 After Deductible	
Tier 3	$90	$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		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	Yes		Yes		Yes	

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.

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 Preferred		BCBS Saver	
	HMO	POS		PPO		PPO	
	In-Network Only	PCP / Plan Approved	Self - Referred	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium Rates (includes MMHG administrative fee)							
Individual	**$1,044.11**	**$1,166.78**		**$2,365.90**		**$641.30**	
EE + 1	**$2,146.87**	**$2,455.48**		**$5,330.69**		**$1,526.74**	
Family	**$2,799.89**	**$3,125.34**		**$6,297.22**		**$2,105.61**	
Calendar Year Deductible Individual	$500	$500	$500	$500	$500	$4,000	$4,000
Family	$1,000	$1,000	$1,000	$1,000	$1,000	$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	$5,000	$5,000	$5,000	$5,000	$5,000	$6,850	$6,850
Family	$10,000	$10,000	$10,000	$10,000	$10,000	$13,700	$13,700
Lifetime Maximum Individual	None	None	None	None	None	None	None
Family	None	None	None	None	None	None	None
Hospital Services - Inpatient							
Hospital Admission	$275, $500, $1500	$275, $500, $1500	20% coinsurance after deductible	$275, $500, $1500	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	$150 copay in ambulatory facility, hospital; $250 per visit in office setting	$150 copay in ambulatory facility, hospital; $250 per visit in office setting	20% coinsurance after deductible	$150 copay in ambulatory facility, hospital; $250 per visit in office setting	20% coinsurance after deductible other	$0 After Deductible	20% coinsurance after deductible
Emergency Room	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$0 After Deductible	$0 After Deductible
	waived if admitted	waived if admitted	waived if admitted	waived if admitted	waived if admitted	waived if admitted	waived if admitted
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	$100 / scan	$100 / scan	20% coinsurance after deductible	$100 / scan	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)	20% coinsurance after deductible	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	Tier 1 $10 Tier 2 $20 Tier 3 $40	Tier 1 $10 Tier 2 $20 Tier 3 $40	20% coinsurance after deductible	Tier 1 $10 Tier 2 $20 Tier 3 $40	20% coinsurance after deductible	$25 Copay After Deductible	20% coinsurance after deductible
Specialist Care Physician Office Visit Copay	Tier 1 $30 Tier 2 $60 Tier 3 $75	Tier 1 $30 Tier 2 $60 Tier 3 $75	20% coinsurance after deductible	Tier 1 $30 Tier 2 $60 Tier 3 $75	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	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy	Up to 60 days per calendar year combined with out of network services (combined with occupational therapy

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	$275, $500, $1500	$275, $500, $1500	20% coinsurance after deductible	$275, $500, $1500	20% coinsurance after deductible	$0 After Deductible	20% coinsurance after deductible
Annual Visit Limits	None	None	None	None	None	None	None
Out-patient treatment	Tier 1 $10 Tier 2 $20 Tier 3 $40	Tier 1 $10 Tier 2 $20 Tier 3 $40	20% coinsurance after deductible	Tier 1 $10 Tier 2 $20 Tier 3 $40	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 After Deductible	$20 After Deductible
Tier 2	$30	$30		$30		$25 After Deductible	$50 After Deductible
Tier 3	$65	$65		$65		$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	$25	$25		$25		$20 After Deductible	
Tier 2	$75	$75		$75		$50 After Deductible	
Tier 3	$165	$165		$165		$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	Yes		Yes		Yes	
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	$2,000 Per Ear every 36 months (all ages)	20% coinsurance after deductible all charges beyond	$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.