CCMHG Plan Benefit Comparison
Blue Cross Blue Shield

Red font indicates plan change

Effective 7-1-2011
Revised 4/13/11 - blue font

BENEFIT	BLUE CROSS BLUE SHIELD							
		NETWORK BLUE	BLUE CARE ELECT PREFERRED		BLUE CARE ELECT PREF PPO RATE SAVER		MASTER HEALTH PLUS	
	NETWORK BLUE	EPO RATE SAVER	In-Network	Out-of-Network	In-Network	Out-of-Network		MASTER MEDICAL
Deductible	None	None	None	$250 per member $500 per family	None	$250 per member $500 per family	None	$50 per member per calendar year for services with 20% coinsurance for some services
Calendar Year Coinsurance Maximum	None	None	None	$1,000 per member $2,000 per family	None	$1,000 per member $2,000 per family	None	None
Lifetime Benefit Maximum	None	None	None	None	None	None	None	None
INPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services)	Nothing	$500 per admission (including maternity care)	Nothing	20% coinsurance* Nothing for emergency/accident admissions	$500 per admission (including maternity care)	20% coinsurance*	Nothing	Nothing
Physician Services	Nothing	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions	Nothing	20% coinsurance*	Nothing	Nothing
Skilled Nursing Facility	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum	20% coinsurance* to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum	20% coinsurance* to 100 days per calendar year benefit maximum	Nothing	Nothing
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% coinsurance* to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% coinsurance*	Nothing	Nothing

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	NETWORK BLUE	NETWORK BLUE EPO RATE SAVER	BLUE CARE ELECT PREFERRED In-Network	BLUE CARE ELECT PREFERRED Out-of-Network	BLUE CARE ELECT PREF PPO RATE SAVER In-Network	BLUE CARE ELECT PREF PPO RATE SAVER Out-of-Network	MASTER HEALTH PLUS	MASTER MEDICAL
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care	$25 copay (waived if admitted or for observation stay)	$75 copay (waived if admitted or for observation stay)	$50 copay(waived if admitted or for observation stay)	$50 copay(waived if admitted or for observation stay)	$$50 copay(waived if admitted or for observation stay)	$75 copay, no deductible (waived if admitted or for observation stay)	Nothing for first treatment of accident; $25 copay for emergency medical care	Nothing
Emergency Room Visits for Medical Care	$25 copay	$75 copay	$50 copay	20% coinsurance*	$75 copay	$75 copay	$25 copay	Nothing
Surgery	Nothing	$250 per admission surgical facility, hospital, or surgical day care unit. Waived for all colonoscopies	Nothing	20% coinsurance*	$250 per admission surgical facility, hospital, or surgical day care unit. Waived for all colonoscopies	20% coinsurance*	Nothing	Nothing
Radiation and Chemotherapy	Nothing	Nothing	Nothing	20% coinsurance*	Nothing	20% coinsurance*	Nothng	Nothing
Diagnostic X-ray and Lab	Nothing	Nothing/Hi tech radiology $50 per category per date service	Nothing	20% coinsurance*	Nothing/Hi tech radiology $50 per category per date service	20% coinsurance*	Nothing	Nothing
Hemodialysis	Nothing	Nothing	Nothing	20% coinsurance*	Nothing	20%coinsurance*	Nothing	Nothing
Physical Therapy	$10 copay to 60 visits per calendar year	$20 copay to 60 visits per calendar year	$10 copay to 100 visits per calendar year	20% coinsurance* to 100 visits per calendar year	$20 copay to 100 visits per calendar year	20% coinsurance to 100 visits per calendar year	$10 Physician Office $25 in Hospital Setting	Nothing (20% coinsurance applies if done in Doctor's Office)

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BENEFIT	NETWORK BLUE	EPO RATE SAVER	In-Network	Out-of-Network	In-Network	Out-of-Network	PLUS	MASTER MEDICAL
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery	$10 copay	$20 copay	$10 copay	20% coinsurance*	$20 copay	20% coinsurance*	Nothing	Nothing
Adult Preventative Exam	$0 copay	$0 copay	$0 copay	20% coinsurance*	$0 copay	20% coinsurance*	$0 copay	$0 copay
Medical Care/Mental Health Care/Substance Abuse Care	$10 copay	$20 copay	$10 copay	20% coinsurance*	$20 copay	20% coinsurance*	$10 copay	20% coinsurance
Well Child Care	$0 copay	$0 copay	$0 copay	20% coinsurance*	$0 copay	20% coinsurance*	$0 copay	$0 copay:
Routine GYN Exam (one per calendar year)	$0 copay	$0 copay	$0 copay	20% coinsurance*	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine Vision Exam	$0 copay (once every 12 months)	$0 copay (once every 12 months)	$0 copay (once per calendar year)	20% coinsurance* (once per calendar year)	$0 copay (once per calendar year)	20% coinsurance* (once per calendar year)	$0 copay	$0 copay
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse Home Health Care	Nothing	Nothing	Nothing	20% coinsurance*	Nothing	20% coinsurance*	Nothing	Nothing
Durable Medical Equipment	Nothing to $1,500 per calendar year benefit maximum (prosthetics at 20% with no maximum)	Nothing to $1,500 per calendar year benefit maximum (prosthetics at 20% with no maximum)	Nothing to $1,500 per calendar year benefit maximum (prosthetics -no member cost)	20% coinsurance* and all charges beyond the calendar year maximum(prosthetics-20% coinsurance-not limited to $1500 DME max)	Nothing to $1,500 per calendar year maximum (prosthetics-no member cost)	20% coinsurance* and all charges beyond the calendar-year maximum (prosthetics 20% coinsurance-not limited to $1500 DME max)	20% coinsurance	20% coinsurance

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Ambulance	Nothing	Nothing	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	Nothing	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	20% coinsurance	20% coinsurance
Routine Pediatric Dental (through age 11)	Nothing	Nothing	All charges	All charges	All charges	All charges	All charges	All charges
Chiropractor Visits	All charges	All charges	$10 copay	20% coinsurance*	$20 copay	20% coinsurance*	$10 copay	20% coinsurance
Prescription Drugs	Formulary drugs: Tier 1: $5.00 copay Tier 2: $15.00 copay Tier 3: $30 copay - 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges	Formulary drugs: Tier 1: $15 copay Tier 2: $30 copay Tier 3: $50 copay up to 30-day supply Mail Order: (90 day supply) Tier 1: $30.00 copay Tier 2: $60.00 copay Tier 3: $100.00 copay	Formulary drugs: Tier 1: $5.00 copay Tier 2: $15.00 copa Tier 3: $30 copay - 30-day supply retail pharmacy or 90-day supply mail Non-formulary drugs: all charges	Same as In-Network at retail pharmacies outside of Massachusetts	Formulary drugs: Tier 1: $15 copay Tier 2: $30 copay Tier 3: $50 copay up to 30-day supply Mail Order: (90 day supply) Tier 1: $30.00 copay Tier 2: $60.00 copay Tier 3: $100.00 copa	Not Covered Not Covered	Retail: Formulary Tier 1: $5 copay Tier 2: $15 copay Tier 3: $30 copay (30 day retail or 90 day mail order) Non-formulary drugs All charges	Retail: Formulary (30 day supply) 20% coinsurance no deductible Mail Order: (90 day supply) Tier 1: $5 copay Tier 2: $15 copay Tier 3: $30 copay Non-formulary drugs All charges
Fitness Benefit	Up to $150 reimbursement toward membership or exercise classes at a health club. See plan details. 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 $150 reimbursement toward membership or exercise classes at a health club. See plan details. 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 $150 reimbursement toward membership or exercise classes at a health club. See plan details. 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 $150 reimbursement toward membership or exercise classes at a health club. See plan details. 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 $150 reimbursement toward membership or exercise classes at a health club. See plan details. 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 $150 reimbursement toward membership or exercise classes at a health club. See plan details. Enroll in a qualified Weight Watchers or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	No Fitness Benefit	No Fitness Benefit

***After Deductible**

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.