FY25-26 Town of Plymouth Benefit Comparison
Blue Cross Blue Shield of Massachusetts

Effective 7/1/25- 6/30/26	BLUE CROSS BLUE SHIELD				
BENEFIT	**BLUE CHOICE (POS)** **In-Network**	**BLUE CHOICE (POS)** **Out-Of-Network**	**BLUE CARE ELECT (PPO)** **In-Network**	**BLUE CARE ELECT (PPO)** **Out-Of-Network**	**Access Blue NE Saver** **In-Network Coverage ONLY**
	Your Responsibility	**Your Responsibility**	**Your Responsibility**	**Your Responsibility**	**Your Responsibility**
Deductible	No deductible	$250 per member per calendar year $500 per family per calendar year	No deductible	$250 per member per calendar year $500 per family per calendar year	$2000 per Individual Membership $4000 per Family Membership
Calendar Year Out OF Pocket Maximum (MOOP)	$6,350 per member per calendar year $12,700 per family per calendar year	$1,000 per member per calendar year $2,000 per family per calendar year	$6,350 per member per calendar year $12,700 per family per calendar year	$1,000 per member per calendar year $2,000 per family per calendar year	$5000 per Individual Contract per plan year $10000 per Family Contract per plan year
Lifetime Benefit Maximum	None	None	None	None	None
Eligible Dependents	***Dependents cover until the end of the calendar month in which they turn 26, regardless of the dependent's financial dependency, student status, or employment status.***	***Dependents cover until the end of the calendar month in which they turn 26, regardless of the dependent's financial dependency, student status, or employment status.***	***Dependents cover until the end of the calendar month in which they turn 26, regardless of the dependent's financial dependency, student status, or employment status.***	***Dependents cover until the end of the calendar month in which they turn 26, regardless of the dependent's financial dependency, student status, or employment status.***	***Dependents cover until the end of the calendar month in which they turn 26, regardless of the dependent's financial dependency, student status, or employment status.***
Waiting Periods/Pre-Existing Condition Exclusion	None	None	None	None	None

BENEFIT	BLUE CHOICE (POS) In-Network	BLUE CHOICE (POS) Out-Of-Network	BLUE CARE ELECT (PPO) In-Network	BLUE CARE ELECT (PPO) Out-Of-Network	Access Blue NE Saver In-Network Coverage ONLY
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INPATIENT					
General Hospital, *Mental Hospital, Substance Abuse Facility* (semi-private room and board and special services)	$300 per admission (including maternity care) (Maximum of 3 Inpatient co-payments per calendar year.)	20% co-insurance after deductible	$300 per admission (including maternity care) (Maximum of 3 Inpatient co-payments per calendar year.)	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible.
Physician Services, Surgical Charges, Anesthesia and Consultations.	No deductible	20% co-insurance after deductible	No deductible	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible.
Skilled Nursing Facility	Nothing up to 100 days per member per calendar year	Not covered; member pays all charges	Nothing up to 100 days per member per calendar year at a semi-private rate	20% co-insurance after deductible (and amount above allowed charge) up to 100 days per calendar year	No Cost AFTER Deductible up to 100 days per member per Calendar Year.
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum	20% co-insurance after deductible up to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% co-insurance after deductible (and amount above allowed charge) up to 60 days per calendar year benefit maximum	No Cost AFTER Deductible up to 60 days per member per Calendar Year.

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OUTPATIENT HOSPITAL					
Emergency Room Visits for Emergency or Accident Care	$100 copay for Emergency Room Services (waived if admitted)	$100 copay for Emergency Room Services (deductible does not apply) (waived if admitted)	$100 copay for Emergency Room Services (waived if admitted)	$100 copay for Emergency Room Services (deductible does not apply) (waived if admitted)	No Cost AFTER Deductible.
Emergency Medical Outpatient Services	$20 copay for office, health center and hospital services	20% co-insurance after deductible	$30 copay for office, health center and hospital services	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible.
OutPatient Surgery	$75 copay (Maximum of 2 outpatient surgery co-payments per calendar year.)	20% co-insurance after deductible	$75 copay (Maximum of 2 outpatient surgery co-payments per calendar year.)	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible.
Radiation and Chemotherapy	No copay	20% co-insurance after deductible	No copay	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible.
High Tech Radiology (MRI, CT, PT Scans)	$50 copayment	20% co-insurance after deductible	$50 copayment	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible.
Hemodialysis	No copay	20% co-insurance after deductible	No copay	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible.

BENEFIT	BLUE CHOICE (POS) In-Network Your Responsibility	BLUE CHOICE (POS) Out-Of-Network Your Responsibility	BLUE CARE ELECT (PPO) In-Network Your Responsibility	BLUE CARE ELECT (PPO) Out-Of-Network Your Responsibility	Access Blue NE Saver In-Network Coverage ONLY Your Responsibility
Physical Therapy	$20 copay per visit up to 60 visits per member per calendar year. In and Out-of-Network combined	20% co-insurance after deductible up to 60 visits per member per calendar year. In and Out-of-Network combined	$30 copay per visit up to 100 visits per member per calendar year. In and Out-of-Network combined	20% co-insurance after deductible (and amount above allowed charge) up to 100 visits per member per calendar year. In and Out-of-Network combined	No Cost AFTER Deductible. Up to 60 Visits per member per Calendar Year for PT and OT.
PHYSICIAN'S OFFICE					
PCP and/or Specialist OV	$20 copay per in-person or telehealth visit	20% co-insurance after deductible	$30 copay per in-person or telehealth visit	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible for in-person or telehealth visit
Surgery	$20 copay	20% co-insurance after deductible	$30 copay	20% co-insurance after deductible (and amount above allowed charge)	No Cost After Deductible.
Medical Care, Mental Health Care, Substance Abuse Care	$20 copay per in-person or telehealth visit	20% co-insurance after deductible	$30 copay per in-person or telehealth visit	20% co-insurance after deductible (and amount above allowed charge)	No Cost AFTER Deductible for in-person or telehealth visit
Well Child Care	No copay for in-person or telehealth visits	20% co-insurance after deductible based on following schedule: 6 visits 1st year 3 visits 2nd year 1 visit per year from age 2-5	No copay per in-person or telehealth visit based on following schedule: 10 visits 1st year 3 visits 2nd year 2 visits for age 2 1 Visit each cal year age 3-18	20% co-insurance after deductible (and amount above allowed charge) 10 visits 1st year 3 visits 2nd year 2 visits for age 2 1 Visit each cal year age 3-18	No Cost for in-person or telehealth visits
Routine GYN Exam **Preventative GYN Exam - $0 copay**	No copay - 1 visit per calendar year	Not covered; member pays all charges	No copay - 1 visit per calendar year	20% co-insurance after deductible (and amount above allowed charge)	No Cost - 1 Exam per member per Calendar Year.

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Routine Vision Exam Preventative Vision Exam - $0 copay	No copay - 1 visit per member per calendar year	Not covered; member pays all charges	No copay - 1 visit per member every 24 months	20% co-insurance after deductible (and amount above allowed charge)	No Cost - 1 Exam per member per Plan Year.
Adult Routine Physicals Preventative Physicals - $0 copay	No copay per in-person or telehealth visit	Not covered; member pays all charges	No copay per in-person or telehealth visit - 1 visit per member per calendar year	20% co-insurance after deductible (and amount above allowed charge)	No Cost for in-person or telehealth visits
Podiatry Benefits - (Routine foot care not covered)	$20 copay for Medically Necessary Footcare for members with systemic circulatory disease	20% co-insurance after deductible for Medically Necessary Footcare for members with systemic circulatory disease	$30 copay for Medically Necessary Footcare for members with systemic circulatory disease	20% co-insurance after deductible (and amount above allowed charge) for Medically Necessary Footcare for members with systemic circulatory disease	No Cost after Deductible.
Family Planning Services	No copay per in-person or telehealth visit	20% co-insurance after deductible	No copay for in-person or telehealth visit	20% co-insurance after deductible (and amount above allowed charge)	No Cost for in-person or telehealth visits

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OTHER OUTPATIENT					
Visiting Nurse Home Health Care	No copay	20% co-insurance after deductible	No copay	20% co-insurance after deductible (and amount above allowed charge)	No Cost after Deductible.
Hospice Services	No copay	20% co-insurance after deductible	No copay	20% co-insurance after deductible (and amount above allowed charge)	No Cost after Deductible.
Cardiac Rehabilitation (When medically necessary and authorized by a plan physician)	$20 copay per visit	20% co-insurance after deductible	$30 copay per visit	20% co-insurance after deductible (and amount above allowed charge)	No Cost after Deductible.
Durable Medical Equipment	20% Coinsurance. Including Prosthetic Devices.	40% co-insurance after deductible. (prosthetics at 20% co-insurance after deductible)	20% Coinsurance. Prosthetic Devices covered at no cost.	40% co-insurance after deductible. (prosthetics at 20% co-insurance after deductible)	No Cost after Deductible.
Ambulance (when medically necessary)	No copay	No copay for emergency transport	No copay	No copay for emergency transport	No Cost after Deductible.
		20% co-insurance after deductible for other medically necessary transport		20% co-insurance after deductible for other medically necessary transport	

BENEFIT	BLUE CHOICE (POS) In-Network Your Responsibility	BLUE CHOICE (POS) Out-Of-Network Your Responsibility	BLUE CARE ELECT (PPO) In-Network Your Responsibility	BLUE CARE ELECT (PPO) Out-Of-Network Your Responsibility	Access Blue NE Saver In-Network Coverage ONLY Your Responsibility
Dental Care	No copay for Pediatric Preventive Dental Care. (1 exam and cleaning every 6 months up to age 12) For Members Under Age 18 - Coverage is provided for preventive dental care such as periodic oral exams, cleanings, and fluoride treatments for members under age 18 who are being treated for conditions of cleft lip and cleft palate.	Not covered; member pays all charges 20% co-insurance after deductible	Not covered For Members Under Age 18 - Coverage is provided for preventive dental care such as periodic oral exams, cleanings, and fluoride treatments for members under age 18 who are being treated for conditions of cleft lip and cleft palate.	Not covered 20% co-insurance after deductible (and amount above allowed amount).	Not covered For Members Under Age 18 - Coverage is provided for preventive dental care such as periodic oral exams, cleanings, and fluoride treatments for members under age 18 who are being treated for conditions of cleft lip and cleft palate.
Chiropractor Visits	$20 copay per visit - 12 visits per calendar year (limited to members age 16 or older)	20% co-insurance after deductible	$30 copay per visit -No benefit limit.	20% co-insurance after deductible (and amount above allowed charge)	No Cost after Deductible.
Prescription Drugs	Formulary drugs: Tier 1: $10 copay Tier 2: $20 copay Tier 3: $35 copay Mail Order: Tier 1: $20 copay Tier 2: $40 copay Tier 3: $70 copay	Same as In-network at participating pharmacies Not covered at non-participating pharmacies; member pays all charges	Formulary drugs: Tier 1: $15 copay Tier 2: $25 copay Tier 3: $40 copay Mail order: Tier 1: $30 copay Tier 2: $50 copay Tier 3: $80 copay	Same as In-network at participating pharmacies Not covered at non-participating pharmacies; member pays all charges	After Overall Deductible Formulary drugs: Tier 1: $10 copay Tier 2: $25 copay Tier 3: $50 copay Mail Order: Tier 1: $20 copay Tier 2: $50 copay Tier 3: $110 copay

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	30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges		30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges		30-day supply retail pharmacy or 90-day supply mail service or designated retail Non-formulary drugs: all charges

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OTHER BENEFITS					
Fitness Benefit/Special Programs - (See Plan for Details)	$150 fitness reimbursement per membership per calendar year for in-person, virtual fitness classes or home fitness equipment 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.	$150 fitness reimbursement per membership per calendar year for in-person, virtual fitness classes or home fitness equipment Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs.	$150 fitness reimbursement per membership per calendar year for in-person, virtual fitness classes or home fitness equipment 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.	$150 fitness reimbursement per membership per calendar year for in-person, virtual fitness classes or home fitness equipment Discounts on eyewear, acupuncture, massage therapy, nutrition counseling, personal health assessment, lifestart prenatal care programs.	$150 fitness reimbursement per membership per calendar year for in-person, virtual fitness classes or home fitness equipment 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.

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.