

Town of Carver FY27 - Plan Offering with Alternatives compared to current Gateway Plans

Network	Gateway Health Group \$500 Deductible HMO		Network Blue NE \$500 Deductible BM3 HMO		Gateway \$500 Deductible PPO		Blue Care Elect \$500 Deductible BM3 PPO		Network Blue SELECT \$1,000 Deductible HMO		Access Blue Saver NE HMO**	
	All 6 New England States		All 6 New England States		National Network		National Network		Limited Network - MA Only		All 6 New England States	
Deductible Single/Family	\$500/\$1,000	\$500/\$1,000	\$500/\$1,000	\$500/\$1,000	In-Network \$500/\$1,000	Out-of-Network \$500/\$1,000	In-Network \$500/\$1,000	Out-of-Network \$500/\$1,000	\$1,000/\$2,000	\$1,000/\$2,000	\$2,500/\$5,000	\$2,500/\$5,000
Max Out of Pocket Medical Pharmacy	\$2,000/\$4,000 \$2,000/\$4,000	\$2,000/\$4,000 \$2,000/\$4,000	\$2,500/\$5,000 \$1,000/\$2,000	\$2,500/\$5,000 \$1,000/\$2,000	\$2,000/\$4,000 \$2,000/\$4,000	\$2,000/\$4,000 \$2,000/\$4,000	\$2,500/\$5,000 \$1,000/\$2,000	\$2,500/\$5,000 \$1,000/\$2,000	\$2,500/\$5,000 \$1,000/\$2,000	\$2,500/\$5,000 \$1,000/\$2,000	6,450/\$12,500 Combine Medical and Rx	6,450/\$12,500 Combine Medical and Rx
Preventive Care - Routine Physicals & Gynecological exams	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible	Covered in full. No Deductible
PCP Copay	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$25 after deductible	\$25 after deductible
Specialist Copay	\$60	\$60	\$60	\$60	\$60	\$60	\$60	\$60	\$60	\$60	\$35 after deductible	\$35 after deductible
ER (copay waived if admitted)	\$100 no deductible	\$100 no deductible	\$100 after deductible	\$100 after deductible	\$100 no deductible	\$60 after deductible (limited coverage)	\$100 no deductible	\$60 after deductible (limited coverage)	\$100 after deductible	\$100 after deductible	\$150 after deductible	\$150 after deductible
Urgent Care	\$60	\$60	\$60	\$60	\$60	\$60	\$60	\$60	\$60	\$60	\$35 after deductible	\$35 after deductible
Short Term Rehab. Therapy	\$20 (up to 60 visits)	\$20 (up to 60 visits)	\$20 (30 visits pcy per type of therapy)	\$20 (30 visits pcy per type of therapy)	\$20 (up to 60 visits)	20% after deductible	\$20 (30 visits pcy per type of therapy)	20% after deductible	\$20 (30 visits pcy per type of therapy)	\$20 (30 visits pcy per type of therapy)	\$35 after deductible (30 visits pcy per type of therapy)	\$35 after deductible (30 visits pcy per type of therapy)
Speech Therapy	\$20	\$20	\$20	\$20	\$20	20% after deductible	\$20	20% after deductible	\$20	\$20	\$20 after deductible	\$20 after deductible
Chiropractic	\$20	\$20	\$20 (20 visits per calendar year)	\$20 (20 visits per calendar year)	\$20	20% after deductible	\$20	20% after deductible	\$20 (20 visits per calendar year)	\$20 (20 visits per calendar year)	\$20 after deductible	\$20 after deductible
Behavior Health Office Visit	\$20	\$20	\$10	\$10	\$20	20% after deductible	\$10	20% after deductible	\$10	\$10	\$20 after deductible	\$20 after deductible
Diagnostic Lab & X-Ray	nothing after Deductible	nothing after Deductible	nothing after deductible	nothing after deductible	nothing after Deductible	20% after deductible	nothing after deductible	20% after deductible	nothing after deductible	nothing after deductible	\$20 after deductible	\$20 after deductible
High Tech Imaging (CT, MRI & PET Scan)	\$100 per after Deductible	\$100 per after Deductible	\$100 per category per service date after deductible	\$100 per category per service date after deductible	\$100 per after Deductible	20% after deductible	\$100 per category per service date after deductible	20% after deductible	\$100 per category per service date after deductible	\$100 per category per service date after deductible	\$125 per category per service date after deductible	\$125 per category per service date after deductible
Inpatient Hospitalization	\$500 after Deductible	\$500 after Deductible	General Hospitals: \$275 after deductible Higher Cost Share Hospitals: \$1,500 after deductible	General Hospitals: \$275 after deductible Higher Cost Share Hospitals: \$1,500 after deductible	\$500 after Deductible	20% Coinsurance after deductible	General Hospitals: \$275 after deductible Higher Cost Share Hospitals: \$1,500 after deductible	20% Coinsurance after deductible	\$275 after deductible *	\$275 after deductible *	\$500 after deductible	\$500 after deductible
Outpatient Day Surgery	\$250 after Deductible	\$250 after Deductible	\$250 after deductible	\$250 after deductible	\$250 after Deductible	20% Coinsurance after deductible	\$250 after deductible	20% Coinsurance after deductible	\$250 after deductible	\$250 after deductible	\$250 after deductible	\$250 after deductible
Retail Rx Copay	Rx Deductible: \$100/\$200 \$10/30/60	Rx Deductible: \$100/\$200 \$10/30/60	Rx Deductible: \$100/\$200 \$10/30/65	Rx Deductible: \$100/\$200 \$10/30/65	Rx Deductible: \$100/\$200 \$10/30/60	not covered	Rx Deductible: \$100/\$200 \$10/30/65	not covered	Rx Deductible: \$100/\$200 \$10/30/65	Rx Deductible: \$100/\$200 \$10/30/65	Deductible then: \$10/30/65	Deductible then: \$10/30/65
Mail Order Rx Copay	\$20/75/165	\$20/75/165	\$25/75/165	\$25/75/165	\$20/75/165	not covered	\$25/75/165	not covered	\$25/75/165	\$25/75/165	\$25/75/165	\$25/75/165

Notes:

HCCS Hospitals include: Baystate Medical Center, Brigham & Women's, Dana Farber, Mass General, Boston Children's Hospital, Cape Cod Hospital, Fairview Hospital and UMass Memorial Medical Center.

** The Access Blue Saver Plans - are High Deductible Health Plans - the deductible must be met in full. Anyone enrolling in family coverage must meet the full family deductible.

* The Select Limited Network which uses a Massachusetts Limited Network of Providers. There are no tiering of hospitals on these plans.