MIIA Nonprofit Locally based Member driven
Serving Massachusetts communities since 1982

Town of Marion Health Plan Offerings effective July 1, 2023

MASSACHUSETTS

BENEFIT	HMO Blue NE $250 Dedutible w/ HCCS (Benchmark 1)	HMO Blue NE $500 Deductible w/ HCCS (Benchmark 3)	Blue Care Elect- $500 Deductible w/HCCS - PPO	
			In-Network	Out-of-Network
Deductible	$250 / $750 (member / family)	$500/ $1,000 (member / family)	$500 / $1,000 (member / family)	
Out of Pocket Maximum	Medical Services: $2,000 individual / $4,000 family Prescription Services: $2,000 individual / $4,000 family	Medical Services: $2,000 individual / $4,000 family Prescription Services: $2,000 individual / $4,000 family	Medical Services: $2,000 individual / $4,000 family Prescription Services: $2,000 individual / $4,000 family	
Preventive Care Visits	$0	$0	$0	20% coinsurance after deductible
PCP Office Visit	$20	$20	$20	20% coinsurance after deductible
Specialist Office Visit	$35	$60	$60	20% coinsurance after deductible
Emergency Room	$100 (waived if admitted)	$100 (waived if admitted)	$100 (waived if admitted)	
Inpatient Hospital Admission	· General care hospital - $300, after deductible · Higher cost share hospital - $700, after deductible	· General care hospital - $500, after deductible · Higher cost share hospital - $1,000 after deductible	· General care hospital - $500, after deductible · Higher cost share hospital - $1,000, after deductible	20% coinsurance after deductible
Ambulatory Day/Outpatient Surgical Day	$150 after deductible	$250 after deductible	$250 after deductible	20% coinsurance after deductible
Diagnostic X-rays and Lab Tests	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible
MRI, CT and PET scans and Nuclear Imaging	$100 per date of service after deductible	$100 per date of service after deductible	$100 per date of service after deductible	20% coinsurance after deductible
Short-Term Physical and Occupational Therapy	$20 (up to 60 visits pcy)	$20 (up to 60 pcy)	$20 (up to 60 visits pcy)	20% coinsurance after deductible
Routine Vision Exam	Covered in full (one visit every 24 months)	Covered in full (one visit every 24 months)	Covered in full (one visit every 24 months)	20% coinsurance after deductible
Prescription Drug - Retail RX (up to 30-day supply) - Mail Order Drug RX (up to 90-day supply)	 $10/25/50 $20/50/110	Rx Deductible: $100/$200 $10/30/65 $20/75/165	Rx Deductible: $100/$200 $10/30/65 $20/75/165	 not covered not covered

Monthly Employee Contribution Rates:			
Individual	$481.63	$457.07	$652.95
Family	$1,295.74	$1,235.87	$1,590.99
Employee Contribution Rates:			
Individual	$240.82	$228.54	$326.48
Family	$647.87	$617.94	$795.50