

## City of Boston Non-Medicare Plan Comparison Chart (Effective July 1, 2022)

Covered Services	<b>Mass General Brigham Value HMO</b>	<b>BCBS Standard HMO</b> <i>(Network Blue New England)</i>	<b>BCBS PPO</b> <i>(Blue Care Elect Preferred)</i>
<b>Network</b>	In-Network	In-Network Only	In-Network/Out-of-Network
<b>Monthly Rates</b>	\$170.56 Individual \$452.27 Family	\$205.53 Individual \$544.83 Family	\$376.61 Individual \$998.01 Family
<b>Service Area</b>	Massachusetts-based	New England-Based	Anywhere in United States
<b>Deductible</b> <i>(per plan year)</i>	\$0	\$100 per member, up to \$200 per family	In-Network: \$250 per member, up to \$500 per family Out-of-Network: \$350 per member, up to \$875 per family
<b>Out of Pocket Maximum</b>			
In-Network <i>(applies to all out-of-pocket costs for covered medical and prescription drug services)</i>	\$4,500 per member, up to \$9,000 per family	\$4,500 per member, up to \$9,000 per family	\$4,500 per member, up to \$9,000 per family
Out-of-Network <i>(applies to deductible and co-insurance)</i>	No Coverage	No Coverage	\$4,500 per member, up to \$9,000 per family
<b>Preventive Care Visits, Health Screenings, and Immunization</b>	\$0	\$0	In-Network: \$0 Out-of-Network: 20% co-insurance after deductible
<b>Office Visit Copays</b> <i>(Non-Preventive)</i>	\$20 per primary care visit \$30 per specialty care visit	\$20 per primary care visit \$35 per specialty care visit	In-Network: \$20 per primary care visit \$35 per specialty care visit Out-of-Network: 20% co-insurance after deductible
<b>Chiropractor Visit</b>	Not Covered	Not Covered	In-Network: \$35 copay Out-of-Network: 20% co-insurance after deductible
<b>Physical Therapy</b>	\$20 copay  Up to 60 visits per plan year	\$20 copay  Up to 60 visits per plan year	In-Network: \$20 copay Out-of-Network: 20% co-insurance after deductible  Up to 100 visits per plan year
<b>Prescription Drugs</b> <i>(must be purchased from participating pharmacies unless otherwise noted; no cost-sharing on birth control at Tier 1 only)</i>	Up to a 30-day supply at a retail pharmacy: Tier 1 – \$10 copay Tier 2 – \$30 copay Tier 3 – \$55 copay  Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – \$20 copay Tier 2 – \$60 copay Tier 3 – \$135 copay	Up to a 30-day supply at a retail pharmacy: Tier 1 – \$10 copay Tier 2 – \$30 copay Tier 3 – \$55 copay  Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – \$20 copay Tier 2 – \$60 copay Tier 3 – \$135 copay	Up to a 30-day supply at a retail pharmacy: Tier 1 – \$10 copay Tier 2 – \$30 copay Tier 3 – \$55 copay  Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – \$20 copay Tier 2 – \$60 copay Tier 3 – \$135 copay

All plan accumulators (out-of-pocket limits, deductibles, therapy visits, etc.) will run on a plan year (July 1<sup>st</sup> – June 30<sup>th</sup>).

**This comparison chart is not a comprehensive explanation of benefits. Please see the plan's Schedule of Benefits and/or Summary of Benefits for additional information.**

<b>Covered Services</b>	<b>Mass General Brigham Value HMO</b>	<b>BCBS Standard HMO</b> <i>(Network Blue New England)</i>	<b>BCBS PPO</b> <i>(Blue Care Elect Preferred)</i>
<b>Diagnostic Test</b> <i>(X-ray, blood work)</i>	\$0	\$0 after deductible	In-Network: \$0 after deductible Out-of-Network: 20% co-insurance after deductible
<b>Advanced Imaging</b> <i>(CT/PET scans, MRIs)</i>	\$50 copay*	\$100 copay after deductible*	In-Network: \$100 copay after deductible* Out-of-Network: 20% co-insurance after deductible
<b>Outpatient Hospital</b>	\$50 copay*	\$100 copay after deductible*	In-Network: \$100 copay after deductible* Out-of-Network: 20% co-insurance after deductible
<b>Inpatient Hospital and Skilled Nursing Care</b>	\$50 copay*	\$100 copay after deductible*	In-Network: \$100 copay after deductible* Out-of-Network: 20% co-insurance after deductible
<b>Behavioral Health Services</b> <i>(Mental Health or Substance Use Disorder)</i>	Outpatient services: \$20 copay	Outpatient services: \$20 copay	Outpatient services: \$20 copay
	Inpatient services: \$0	Inpatient services: \$0	Inpatient services: \$0 Out-of-Network: 20% co-insurance after deductible
<b>Emergency Room Care</b>	\$100 copay per visit, waived if admitted to hospital	\$100 copay after deductible, waived if admitted to hospital	\$100 copay after deductible, waived if admitted to hospital
<b>Emergency Medical Transportation</b>	\$0	\$0 after deductible	\$0 after deductible
<b>Home Health Care</b>	\$0	\$0 after deductible	In-Network: \$0 after deductible
			Out-of-Network: 20% co-insurance after deductible
<b>Durable Medical Equipment</b>	\$0	\$0 after deductible	In-Network: \$0 after deductible
			Out-of-Network: 20% co-insurance after deductible
<b>Routine Vision Care</b>	\$30 copay	\$20 copay	In-Network: \$0
	Once every 12 months	Once per plan year	Out-of-Network: 20% co-insurance after deductible Once every 24 months (In- & Out-of-Network combined)
<b>Preventative Dental Care</b>	Up to Age 12 – \$0	Up to Age 13 – \$0	Not Covered
	1 visit every 6 months	2 visits per plan year	

\* Maximum of one copayment per category (Advanced Imaging, Outpatient Hospital, and Inpatient Hospital) per plan year.

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