City of Boston Non-Medicare Plan Comparison Chart (Effective July 1, 2019)

Covered Services	Blue Cross Blue Shield Blue Care Elect Preferred PPO	Harvard Pilgrim HMO	AllWays Health Partners HMO
Network	In-Network/Out-of-Network	In-Network Only	In-Network Only
Monthly Rates	$386.36 Individual $953.68 Family	$166.27 Individual $447.46 Family	$138.58 Individual $367.38 Family
Service Area	Anywhere in United States*	Massachusetts-Based	Massachusetts-Based
Deductible *(per calendar year)*	In-Network: $0 Out-of-Network: $250 per member up to $750 per family	$0	$0
Out of Pocket Maximum			
In-Network *(applies to all out-of-pocket costs for covered medical and prescription drug services)*	$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 *(applies to co-insurance only)*	$4,500 per member, up to $9,000 per family	No Coverage	No Coverage
Preventive Care Visits & Health Screenings	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0
Office Visits (Non-Preventive) Copays	In-Network: $20 per primary care visit $30 per specialty care visit Out-of-Network: 20% co-insurance after deductible	$20 per primary care visit $30 per specialty care visit	$20 per primary care visit $30 per specialty care visit
Prescription Drugs *(must be purchased from participating pharmacies unless otherwise noted; no cost sharing on birth control at Tier 1 only)*	Up to a 30-day supply at a retail pharmacy: Tier 1 – $10 copay Tier 2 – $25 copay Tier 3 – $45 copay Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – $20 copay Tier 2 – $50 copay Tier 3 – $100 copay	Up to a 30-day supply at a retail pharmacy: Tier 1 – $10 copay Tier 2 – $25 copay Tier 3 – $45 copay Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – $20 copay Tier 2 – $50 copay Tier 3 – $100 copay	Up to a 30-day supply at a retail pharmacy: Tier 1 – $10 copay Tier 2 – $25 copay Tier 3 – $45 copay Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – $20 copay Tier 2 – $50 copay Tier 3 – $100 copay
Hospitalization (Medical/Mental Health/Substance Use Disorder)	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0

*Out-of-Network coverage includes some international coverage. Refer to your Summary Plan Description for details.

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.

Covered Services	Blue Cross Blue Shield Blue Care Elect Preferred PPO	Harvard Pilgrim HMO	AllWays Health Partners HMO
Routine Pediatric Care	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0
Emergency Room	$100 copay per visit, waived if admitted to hospital	$100 copay per visit, waived if admitted to hospital	$100 copay per visit, waived if admitted to hospital
Ambulance Services *(Emergency Transport)*	In-Network: $0 Out-of-Network: $0	$0	$0
X-Ray and Lab	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0
Chiropractic Services	In-Network: $30 copay Out-of-Network: 20% co-insurance after deductible	Not Covered	Not Covered
Durable Medical Equipment	In-Network: $0	In-Network: $0	In-Network: $0
	Out-of-Network: 20% co-insurance after deductible	Out-of-Network: Not Covered	Out-of-Network: Not Covered
	Hair Prosthesis/Wigs: Covered in full; limitations apply	Hair Prosthesis/Wigs: 20% co-insurance	Hair Prosthesis/Wigs: Covered in full
Home Health Care	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0
Physical Therapy	In-Network: $30 copay Out-of-Network: 20% co-insurance after deductible	$20 copay per visit	$20 copay per visit
	Up to 100 visits per calendar year	Up to 60 visits per calendar year	Up to 60 visits per calendar year
Routine Vision Care	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$20 copay per visit	$30 copay per visit
	Once every 24 months (In- & Out-of-Network combined)	Once per calendar year	Once every 12 months
Preventative Dental Care	Not covered	Up to Age 13 – $0 Age 13 and over - $20	Up to Age 12 – $0
		Two visits per calendar year	One visit every six months