

# City of Boston Non-Medicare Plan Comparison Chart (Effective July 1, 2018)

Covered Services	Blue Cross Blue Shield Blue Care Elect Preferred PPO	Harvard Pilgrim HMO	Neighborhood Health Plan HMO
<b>Network</b>	In-Network/Out-of-Network	In-Network Only	In-Network Only
<b>Monthly Rates</b>	\$379.47 Individual \$936.52 Family	\$163.28 Individual \$439.53 Family	\$136.11 Individual \$360.88 Family
<b>Service Area</b>	Anywhere in United States*	Massachusetts-Based	Massachusetts-Based
<b>Deductible</b> (per calendar year)	In-Network: \$0 Out-of-Network: \$250 per member up to \$750 per family	\$0	\$0
<b>Out of Pocket Maximum</b>			
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
<b>Preventive Care Visits &amp; Health Screenings</b>	In-Network: \$0 Out-of-Network: 20% co-insurance after deductible	\$0	\$0
<b>Office Visits (Non-Preventive) Copays</b>	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
<b>Prescription Drugs</b> (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
<b>Hospitalization (Medical/Mental Health/Substance Use Disorder)</b>	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	Neighborhood Health Plan HMO
Routine Pediatric Care	In-Network: \$0	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
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	\$0	\$0
	Out-of-Network: \$0		
X-Ray and Lab	In-Network: \$0	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
Chiropractic Services	In-Network: \$30 copay	Not Covered	Not Covered
	Out-of-Network: 20% co-insurance after deductible		
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	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
Physical Therapy	In-Network: \$30 copay	\$20 copay per visit	\$20 copay per visit
	Out-of-Network: 20% co-insurance after deductible		
	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	\$20 copay per visit	\$30 copay per visit
	Out-of-Network: 20% co-insurance after deductible		
	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