

# City of Boston Non-Medicare Plan Comparison Chart (Effective July 1, 2016)

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>	\$331.11 Individual \$817.05 Family	\$146.51 Individual \$394.16 Family	\$122.72 Individual \$325.39 Family
<b>Service Area</b>	Anywhere in United States*	Massachusetts-Based	Massachusetts-Based
<b>Deductible</b> <i>(per calendar year)</i>	In-Network: \$0	\$0	\$0
	Out-of-Network: \$250 per member up to \$750 per family		
<b>Out of Pocket Maximum</b>			
<b>In-Network</b> <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
<b>Out-of-Network</b> <i>(applies to co-insurance only)</i>	\$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	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
<b>Office Visits (Non-Preventive) Copays</b>	In-Network: \$20 per primary care visit \$30 per specialty care visit	\$20 per primary care visit	\$20 per primary care visit
	Out-of-Network: 20% co-insurance after deductible	\$30 per specialty care visit	\$30 per specialty care visit
<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 – \$25 copay Tier 3 – \$45 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 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 90-day supply at a Mail-order pharmacy: Tier 1 – \$20 copay Tier 2 – \$50 copay Tier 3 – \$100 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 Abuse)</b>	In-Network: \$0	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		

\*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.

<b>Covered Services</b>	<b>Blue Cross Blue Shield Blue Care Elect Preferred PPO</b>	<b>Harvard Pilgrim HMO</b>	<b>Neighborhood Health Plan HMO</b>
<b>Routine Pediatric Care</b>	In-Network: \$0	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
<b>Emergency Room</b>	\$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
<b>Ambulance Services (Emergency Transport)</b>	In-Network: \$0	\$0	\$0
	Out-of-Network: \$0		
<b>X-Ray and Lab</b>	In-Network: \$0	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
<b>Chiropractic Services</b>	In-Network: \$30	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
<b>Durable Medical Equipment</b>	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
<b>Home Health Care</b>	In-Network: \$0	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
<b>Physical Therapy</b>	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		
<b>Routine Vision Care</b>	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
<b>Preventative Dental Care</b>	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