

# Non-Medicare Plan Comparison Chart

Health Plan	Blue Cross Blue Shield Blue Care Elect Preferred PPO	Harvard Pilgrim HMO	Neighborhood Health Plan HMO
Network	In-Network/Out-of-Network	In-Network Only	In-Network Only
<b>Monthly Rates</b>	\$295.88 Individual \$730.12 Family	\$133.32 Individual \$358.64 Family	\$114.64 Individual \$303.84 Family
<b>Service Area</b>	Anywhere in United States*	Massachusetts-Based	Massachusetts-Based
<b>Deductible</b> <i>(per calendar year)</i>	In-Network: \$0 Out-of-Network: \$250 per member up to \$750 per family	\$0	\$0
<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 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 Out-of-Network: 20% co-insurance after deductible	\$0	\$0
<b>Office Visits (Non-preventive)</b>	In-Network: • \$20 copay per primary care visit • \$30 copay per specialty care visit Out-of-Network: 20% co-insurance after deductible	• \$20 copay per primary care visit • \$30 copay per specialty care visit	• \$20 copay per primary care visit • \$30 copay 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 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 Abuse)</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.

## Non-Medicare Plan Comparison Chart

Health Plan	Blue Cross Blue Shield Blue Care Elect Preferred PPO	Harvard Pilgrim HMO	Neighborhood Health Plan HMO
Network	In-Network/Out-of-Network	In-Network Only	In-Network Only
<b>Routine Pediatric Care</b>	In-Network: \$0 Out-of-Network: 20% co-insurance after deductible	\$0	\$0
<b>Adult Physicals</b>	In-Network: \$0 Out-of-Network: 20% co-insurance after deductible	\$0	\$0
<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</b>			
Emergency Transport	In-Network: \$0	\$0	\$0
	Out-of-Network: \$0		
Medically Necessary Non-Emergency Transport	In-Network: \$0	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
<b>X-Ray and Lab</b>	In-Network: \$0	\$0	\$0
	Out-of-Network: 20% co-insurance after deductible		
<b>Chiropractic Care</b>	In-Network: \$30 copay per visit	Not covered	Not covered
	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		

Health Plan	Blue Cross Blue Shield Blue Care Elect Preferred PPO	Harvard Pilgrim HMO	Neighborhood Health Plan HMO
Network	In-Network/Out-of-Network	In-Network Only	In-Network Only
<b>Physical Therapy</b>	In-Network: \$20 copay per visit	\$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
<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	Up to Age 12 – \$0
		Two visits per calendar year	One visit every six months

