City of Boston Non-Medicare Plan Comparison Chart (Effective July 1, 2023)

Covered Services	Mass General Brigham Value HMO	BCBS Standard HMO (Network Blue New England)	BCBS PPO (Blue Care Elect Preferred)
Network	In-Network	In-Network Only	In-Network/Out-of-Network
Monthly Rates	$174.59 Individual $462.93 Family	$210.34 Individual $557.70 Family	$385.45 Individual $1,021.67 Family
Service Area	Massachusetts-based	New England-Based	Anywhere in United States
Deductible *(per plan year)*	$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
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 deductible and co-insurance)*	No Coverage	No Coverage	$4,500 per member, up to $9,000 per family
Preventive Care Visits, Health Screenings, and Immunization	$0	$0	In-Network: $0 Out-of-Network: 20% co-insurance after deductible
Office Visit Copays *(Non-Preventive)*	$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
Chiropractor Visit	$30 copay	$30 copay	In-Network: $35 copay Out-of-Network: 20% co-insurance after deductible
Physical Therapy	$20 copay	$20 copay	In-Network: $20 copay Out-of-Network: 20% co-insurance after deductible
	Up to 60 visits per plan year	Up to 60 visits per plan year	Up to 100 visits per plan year
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 – $30 copay Tier 3 – $55 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 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 90-day supply at a Mail-order pharmacy: Tier 1 – $20 copay Tier 2 – $60 copay Tier 3 – $135 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 1st – June 30th).

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	Mass General Brigham Value HMO	BCBS Standard HMO *(Network Blue New England)*	BCBS PPO *(Blue Care Elect Preferred)*
Diagnostic Test *(X-ray, blood work)*	$0	$0 after deductible	In-Network: $0 after deductible Out-of-Network: 20% co-insurance after deductible
Advanced Imaging *(CT/PET scans, MRIs)*	$50 copay*	$100 copay after deductible*	In-Network: $100 copay after deductible* Out-of-Network: 20% co-insurance after deductible
Outpatient Hospital	$50 copay*	$100 copay after deductible*	In-Network: $100 copay after deductible* Out-of-Network: 20% co-insurance after deductible
Inpatient Hospital and Skilled Nursing Care	$50 copay*	$100 copay after deductible*	In-Network: $100 copay after deductible* Out-of-Network: 20% co-insurance after deductible
Behavioral Health Services (Mental Health or Substance Use Disorder)	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
Emergency Room Care	$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
Emergency Medical Transportation	$0	$0 after deductible	$0 after deductible
Home Health Care	$0	$0 after deductible	In-Network: $0 after deductible Out-of-Network: 20% co-insurance after deductible
Durable Medical Equipment	$0	$0 after deductible	In-Network: $0 after deductible Out-of-Network: 20% co-insurance after deductible
Routine Vision Care	$30 copay	$20 copay	In-Network: $0 Out-of-Network: 20% co-insurance after deductible
	Once every 12 months	Once per plan year	Once every 24 months (In- & Out-of-Network combined)
Preventative Dental Care	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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