Boston Medical Center

Benefit Comparison 2020

Plan	BMC Select	BMC Tiered HMO			PPO	
Benefit Comparison		Tier 1	Tier 2	Tier 3	In-Network	Out-of-Network
Deductible	N/A	N/A		$500 Individual $1,000 Family	$1,000 Individual $2,500 Family	$2,000 Individual $5,000 Family
Out-of-Pocket Maximum	$2,500 Individual per calendar year $5,000 Family per calendar year	$3,000 Individual per calendar year $6,000 Family per calendar year			$3,000 Individual $6,000 Family Annual In-network out-of-pocket maximum	$3,000 Individual $6,000 Family Any out of network charges in excess of usual and customary do not apply towards the annual out-of-pocket maximum.
Physician Services						
Preventive Primary Care (routine physical, immunizations)	Covered in Full	Covered in Full		$50 Copay	Covered in Full	Deductible then 20% Coinsurance
Primary Care (Consultations, evaluations and sickness and injury)	$5 Copay	$5 Copay	$20 Copay	$50 Copay	$50 Copay	Deductible then 20% Coinsurance
Specialist Office Visits	$5 Copay	$5 Copay	$25 Copay	$65 Copay	$65 Copay	Deductible then 20% Coinsurance
Emergency Admission	Covered in Full	Covered in Full			Deductible then 10% Coinsurance	Deductible then 10% Coinsurance
Inpatient Services						
Inpatient Hospital Services	Covered in Full	Covered in Full	$200 Copay per admission	Deductible then, $450 Copay per admission	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full	Covered in Full			Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Inpatient Rehabilitation (up to 60 days per calendar year)	Covered in Full	Covered in Full			Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Hospital Outpatient						
Day Surgery	Covered in Full	Covered in Full	$50 Copay per visit	Deductible then, $250 Copay per visit	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Laboratory Tests and X-rays	Covered in Full	Covered in Full			Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Chemotherapy/Radiation	Covered in Full	Covered in Full		Deductible then, $35	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
High End Radiology **(CT/PET/MRI/MRA/NM)**	Covered in Full	Covered in Full	Non Hospital Based $50 Copay Hospital Based $100 Copay	Deductible then, $250 Copay per visit	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Maternity Services						
Prenatal and Postpartum Care	Covered in Full	Covered in Full			Covered in Full	Deductible then 20% Coinsurance
All Hospital Services for Mother	Covered in Full	Covered in Full	$100 Copay per admission	Deductible then, $250 Copay per admission	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Routine Nursery Charges for Newborn	Covered in Full	Covered in Full			Covered in Full	Deductible then 20% Coinsurance
Infertility Services	Cost sharing is dependent upon type of service provided	Cost sharing is dependent upon type of service provided			Cost sharing is dependent upon type of service provided	Deductible then 30% Coinsurance

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Benefit Comparison		Tier 1	Tier 2	Tier 3	In-Network	Out-of-Network
Mental Health - Drug and Alcohol Rehabilitation						
Inpatient	Covered in Full	Covered in Full			Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Outpatient Mental Health and Drug Alcohol Rehab	$5 Copay	$5 Copay			Individual: $50 Copay Group: $10 Copay	Deductible then 20% Coinsurance
Same Day Care Option						
Doctor on Demand (Telemedicine)	$5 Copay	$5 Copay			$5 Copay	N/A
Convenience Care (ex: CVS Minute Clinic)	$5 Copay	$5 Copay			$5 Copay	$5 copay
Urgent Care Stand Alone (non-hospital based)	$5 Copay	$5 Copay			$5 Copay	$5 copay
Emergency Room Care	$125 Copay	$125 Copay			$125 Copay	
Dental						
Preventive Pediatric Dental (children up to age 13)	$5 Copay	$ 5 Copay			$50 Copay	Deductible then 20% Coinsurance
Extraction of Unerupted Teeth Impacted in Bone	Cost sharing is dependent upon type of service provided	Cost sharing is dependent upon type of service provided			Cost sharing is dependent upon type of service provided	Deductible then 20% Coinsurance
Initial Emergency Treatment (within 72 hours of injury)	Cost sharing is dependent upon type of service provided	Cost sharing is dependent upon type of service provided			Cost sharing is dependent upon type of service provided	After deductible, 20% Coinsurance in doctor's office or 30% Coinsurance at a hospital
Other Health Services						
Physical and Occupational Therapy (combined benefit)	$5 Copay	$5 Copay	$20 Copay		$20 Copay	Deductible then 20% Coinsurance
	Covered up to 60 visits per calendar year combined	Covered up to 60 visits per calendar year combined			Covered up to 40 visits per calendar year combined in-network and out-of-network	
Chiropractic Care (limited to $500 per calendar year)	$20 Copay	$20 Copay			$20 Copay	Deductible then 20% Coinsurance
Acupuncture (limited to $500 per calendar year)	$20 Copay	Not Covered			Not Covered	Not Covered
Ambulance Services	Covered in Full	Covered in Full			Deductible then 10% Coinsurance	Deductible then 10% Coinsurance
Durable Medical Equipment	20% Coinsurance	20% Coinsurance			Deductible then 20% Coinsurance	Deductible then 30% Coinsurance

This document is only a summary. The *Schedule of Benefits* governs in the event that the information in this document is different.
Visit **www.healthplansinc.com/bmc** to check each plan's *Schedule of Benefits* and to view a provider directory for each medical plan option.

For Member Services call 1-844-926-2262.

Prescription Drugs - All Plans (through Express Scripts, 877-861-0376)				
Rx Cost Level	30 Day Supply		90 Day Supply	
	BMC Pharmacy	Other Pharmacy	BMC Pharmacy/ BMC Mail Order (Cornerstone)	Mail Order
Tier 1	$5	$20	$10	$40
Tier 2	$10	$40	$20	$80
Tier 3	$20	$80	$60	$240
Tier 4 (Specialty)	$20	20% (up to $250)	$60	20% (up to $750)

HealthPlans, Inc.