Boston Medical Center

Benefit Comparison 2025

Plan	BMC Select	BMC Tiered HMO		HPHC PPO		HDHP with HSA	
Benefit Comparison	BMC Network	Tier 1 Core Network	Tier 2 High Cost Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Network View provider directories at: bmc.healthplansinc.com/members/provider-directory	Boston Medical Center, Good Samaritan Medical Center, St. Elizabeth's Medical Center and select Boston HealthNet Community Health Centers	All HPHC providers not listed in Tier 2, including BMCHS providers	▪ Boston Children's Hospital ▪ Brigham and Women's Hospital ▪ Cape Cod Hospital ▪ Mass General Hospital ▪ South Shore Hospital ▪ UMass Memorial Medical Center	Local: Harvard Pilgrim Netowrk Nationwide: United Health Network	All non-covered providers and hospitals	Local: Harvard Pilgrim Netowrk Nationwide: United Health Network	All non-covered providers and hospitals
Deductible	N/A	$500 Individual $1,000 family		$1,500 Individual $3,000 Family	$2,000 Individual $5,000 Family	$1,650 Single $3,300 Family	$3,300 Single $6,600 Family
Out-of-Pocket Maximum	$2,500 Individual per calendar year $5,000 Family per calendar year	$4,000 Individual per calendar year $8,000 Family per calendar year		$4,000 Individual $8,000 Family Annual In-network out-of-pocket maximum	$4,000 Individual $8,000 Family Any out of network charges in excess of usual and customary do not apply towards the annual out-of-pocket maximum	$5,500 per person up to $11,000 per family	$11,000 per person up to $22,000 per family
Physician Services							
Preventive Primary Care (routine physical, immunizations)	Covered in Full	Covered in Full		Covered in Full	Deductible then 30% Coinsurance	Covered in Full	Deductible then 50% Coinsurance
Primary Care (Consultations, evaluations and sickness and injury)	$10 Copay	$25 Copay		$50 Copay	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Specialist Office Visits	$10 Copay	$40 Copay		$65 Copay	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Emergency Admission for ER	Covered in Full	Covered in Full		Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance
Inpatient Services							
Inpatient Hospital Services	Covered in Full	100% after deductible	$750 copay after deductible	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full	100% after deductible	$750 copay after deductible	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Inpatient Rehabilitation (up to 60 days per calendar year)	Covered in Full	100% after deductible	$750 copay after deductible	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Hospital Outpatient							
Day Surgery	Covered in Full	100% after deductible	$500 copay after deductible	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Laboratory Tests and X-rays	Covered in Full	Covered in Full		Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Chemotherapy/Radiation	Covered in Full	Covered in Full		Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
High End Radiology **(CT/PET/MRI/MRA/NM)** ***Precertification required for all non-BMC providers**	Covered in Full	Non Hospital Based $50 Copay after deductible Hospital Based $100 Copay after deductible	$400 Copay after deductible	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Maternity Services							
Prenatal and Postpartum Care	Covered in Full	Covered in Full		Covered in Full	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
All Hospital Services for Mother	Covered in Full	100% after deductible	$750 copay after deductible	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Routine Nursery Charges **for Newborn**	Covered in Full	Covered in Full		Covered in Full	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% 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	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance

▶ *Continued on reverse side*

Boston Medical Center

Benefit Comparison 2025

Plan	BMC Select	BMC Tiered HMO		HPHC PPO		HDHP with HSA	
Benefit Comparison	BMC Network	Tier 1 Core Network	Tier 2 High Cost Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health - Drug and Alcohol Rehabilitation							
Inpatient	Covered in Full	100% after deductible		Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Outpatient Mental Health and Drug Alcohol Rehab	$10 Copay	$10 Copay		Individual: $50 Copay Group: $10 Copay	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Same Day Care Option							
Doctor on Demand (Telemedicine)	$10 Copay	$10 Copay		$10 Copay		Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Convenience Care (ex: CVS Minute Clinic)	$10 Copay	$10 Copay		$10 Copay		Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Urgent Care Stand Alone (non-hospital based)	$10 Copay	$10 Copay		$10 Copay		Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Emergency Room Care	$150 Copay	$150 Copay		$150 Copay		Deductible then 30% Coinsurance	Deductible then 30% Coinsurance
Dental							
Preventive Pediatric Dental (children up to age 13)	$10 Copay	$10 Copay		$50 Copay	Deductible then 30% Coinsurance	Covered in Full	Deductible then 50% 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 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% 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, 30% Coinsurance in doctor's office or 30% Coinsurance at a hospital	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Other Health Services							
Physical and Occupational Therapy (combined benefit)	$10 Copay Covered up to 60 visits per calendar year combined	$10 Copay Covered up to 60 visits per calendar year combined		$10 Copay Covered up to 40 visits per calendar year combined in-network and out-of-network	Deductible then 30% Coinsurance Covered up to 40 visits per calendar year combined in-network and out-of-network	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Chiropractic Care (limited to 16 visits per calendar year)	$20 Copay	$25 Copay		$20 Copay	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Acupuncture (limited to 16 visits per calendar year)	$20 Copay	$25 Copay		$20 Copay	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Ambulance Services	Covered in Full	Covered in Full		Deductible then 20% Coinsurance		Deductible then 30% Coinsurance	Deductible then 30% Coinsurance
Durable Medical Equipment	20% Coinsurance	20% Coinsurance		Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance

This document is only a summary. The *Schedule of Benefits* governs in the event that the information in this document is different.

Rx Cost Level Prescription Drugs - All Plans (through Express Scripts (ESI), 877-861-0376)	30 Day Supply		90 Day Supply	
	BMCHS Pharmacy	Other Pharmacy	BMCHS Mail Order/ Cornerstone	Mail Order/ ESI
Tier 1	$12	$20	$24	$40
Tier 2	$20	$50	$40	$100
Tier 3	$30	$90	$85	$270
Tier 4 (Specialty)	$30	20% (up to $250)	$90	20% (up to $750)

Healthplansinc.com/bmc 844-926-2262

hpi®