Boston Medical Center

Benefit Comparison 2026

Plan	BMC Select	HPHC PPO		HDHP with HSA		BMC HMO
Benefit Comparison	BMC Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Network View provider directories at: bmc.healthplansinc.com/members/provider-directory	Boston Medical Center, Boston Medical Center- South, Boston Medical Center - Brighton and select Boston HealthNet Community Health Centers	Local: Harvard Pilgrim Network Nationwide: United Health Network	All non-covered providers and hospitals	Local: Harvard Pilgrim Netowrk Nationwide: United Health Network	All non-covered providers and hospitals	HPHC Focus HMO network in MA and the Harvard Pilgrim network in NH, ME, RI and VT)
Deductible	N/A	$2,500 Individual $5,000 Family	$2,500 Individual $5,000 Family	$1,700 Single $3,400 Family	$3,400 Single $6,800 Family	$500 Individual $1,000 family
Out-of-Pocket Maximum	$3,000 Individual per calendar year $6,000 Family per calendar year	$5,000 Individual $10,000 Family Annual In-network out-of-pocket maximum	$6,600 Individual $13,200 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	$4,000 Individual per calendar year $8,000 Family per calendar year
Physician Services						
Preventive Primary Care (routine physical, immunizations)	Covered in Full	Covered in Full	Deductible then 35% Coinsurance	Covered in Full	Deductible then 50% Coinsurance	Covered in Full
Primary Care (Consultations, evaluations and sickness and injury)	$15 Copay	$50 Copay	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$25 Copay
Specialist Office Visits	$15 Copay	$65 Copay	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$40 Copay
Emergency Admission for ER	Covered in Full	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Covered in Full
Inpatient Services						
Inpatient Hospital Services	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	100% after deductible
Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	100% after deductible
Inpatient Rehabilitation (up to 60 days per calendar year)	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	100% after deductible
Hospital Outpatient						
Day Surgery	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	100% after deductible
Laboratory Tests and X-rays	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Covered in Full
Chemotherapy/Radiation	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Covered in Full
High End Radiology **(CT/PET/MRI/MRA/NM)** ***Precertification required for all non-BMC providers**	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Non Hospital Based $50 Copay after deductible Hospital Based $100 Copay after deductible
Maternity Services						
Prenatal and Postpartum Care	Covered in Full	Covered in Full	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Covered in Full
All Hospital Services for Mother	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	100% after deductible
Routine Nursery Charges **for Newborn**	Covered in Full	Covered in Full	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Covered in Full
Infertility Services	Cost sharing is dependent upon type of service provided	Cost sharing is dependent upon type of service provided	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Cost sharing is dependent upon type of service provided

▶ *Continued on reverse side*

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Mental Health - Drug and Alcohol Rehabilitation						
Inpatient	Covered in Full	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	100% after deductible
Outpatient Mental Health and Drug Alcohol Rehab	$15 Copay	Individual: $50 Copay Group: $10 Copay	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$10 Copay
Same Day Care Option						
Doctor on Demand (Telemedicine)	$15 Copay	$15 Copay		Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$15 Copay
Convenience Care (ex: CVS Minute Clinic)	$15 Copay	$15 Copay		Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$15 Copay
Urgent Care Stand Alone (non-hospital based)	$15 Copay	$15 Copay		Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$15 Copay
Emergency Room Care	$150 Copay	$150 Copay		Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	$150 Copay
Dental						
Preventive Pediatric Dental (children up to age 13)	$15 Copay	$50 Copay	Deductible then 35% Coinsurance	Covered in Full	Deductible then 50% Coinsurance	$10 Copay
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	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Cost sharing is dependent upon type of service provided
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	After deductible, 35% Coinsurance in doctor's office or 35% Coinsurance at a hospital	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Cost sharing is dependent upon type of service provided
Other Health Services						
Physical and Occupational Therapy (combined benefit)	$15 Copay Covered up to 60 visits per calendar year combined	$15 Copay Covered up to 40 visits per calendar year combined in-network and out-of-network	Deductible then 35% Coinsurance Covered up to 40 visits per calendar year combined in-network and out-of-network	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$15 Copay Covered up to 60 visits per calendar year combined
Chiropractic Care (limited to 16 visits per calendar year)	$20 Copay	$20 Copay	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$25 Copay
Acupuncture (limited to 16 visits per calendar year)	$20 Copay	$20 Copay	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	$25 Copay
Ambulance Services	Covered in Full	Deductible then 20% Coinsurance		Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Covered in Full
Durable Medical Equipment	20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 35% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	20% Coinsurance

This document is only a summary. The *Schedule of Benefits* governs in the event that the information in this document is different.
For represented employees, please refer to your CBA.

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)

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