Boston Medical Center

Benefit Comparison 2023

Plan	BMC Select	BMC Tiered HMO		HPHC PPO	
Benefit Comparison	BMC Network	Tier 1 Core Network	Tier 2 High Cost Network	In-Network	Out-of-Network
Network View provider directories at: bmc.healthplansinc.com/members/provider-directory	Boston Medical Center and select Community Health Centers	All HPHC providers not listed in Tier 2, including BMC providers	▪ Boston Children's Hospital ▪ Brigham and Women's Hospital ▪ Cape Cod Hospital ▪ Mass General Hospital ▪ UMass Memorial Medical Center	Local: Harvard Pilgrim Netowrk Nationwide: United Health Network	All non-covered providers and hospitals
Deductible	N/A	N/A	N/A	$1,500 Individual $3,000 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		Covered in Full	Deductible then 30% Coinsurance
Primary Care (Consultations, evaluations and sickness and injury)	$7 Copay	$25 Copay		$50 Copay	Deductible then 30% Coinsurance
Specialist Office Visits	$7 Copay	$30 Copay		$65 Copay	Deductible then 30% Coinsurance
Emergency Admission for ER	Covered in Full	Covered in Full		Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Inpatient Services					
Inpatient Hospital Services	Covered in Full	$250 Copay per Admission	$1,000 Copay per Admission	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full	Covered in Full	$1,000 Copay per Admission	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
Inpatient Rehabilitation (up to 60 days per calendar year)	Covered in Full	Covered in Full	$1,000 Copay per Admission	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
Hospital Outpatient					
Day Surgery	Covered in Full	$100 copay per visit	$650 copay per visit	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
Laboratory Tests and X-rays	Covered in Full	Covered in Full		Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
Chemotherapy/Radiation	Covered in Full	Covered in Full		Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
High End Radiology **(CT/PET/MRI/MRA/NM)**	Covered in Full	Non Hospital Based $50 Copay Hospital Based $100 Copay	$400 Copay	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
Maternity Services					
Prenatal and Postpartum Care	Covered in Full	Covered in Full		Covered in Full	Deductible then 30% Coinsurance
All Hospital Services for Mother	Covered in Full	$100 Copay per admission	$1,000 Copay per Admission	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
Routine Nursery Charges **for Newborn**	Covered in Full	Covered in Full		Covered in Full	Deductible then 30% 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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Boston Medical Center
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Mental Health - Drug and Alcohol Rehabilitation					
Inpatient	Covered in Full	Covered in Full		Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
Outpatient Mental Health and Drug Alcohol Rehab	$7 Copay	$7 Copay		Individual: $50 Copay Group: $10 Copay	Deductible then 30% Coinsurance
Same Day Care Option					
Doctor on Demand (Telemedicine)	$7 Copay	$7 Copay		$7 Copay	
Convenience Care (ex: CVS Minute Clinic)	$7 Copay	$7 Copay		$7 Copay	
Urgent Care Stand Alone (non-hospital based)	$7 Copay	$7 Copay		$7 Copay	
Emergency Room Care	$150 Copay	$150 Copay		$150 Copay	
Dental					
Preventive Pediatric Dental (children up to age 13)	$7 Copay	$ 7 Copay		$50 Copay	Deductible then 30% 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
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
Other Health Services					
Physical and Occupational Therapy (combined benefit)	$7 Copay Covered up to 60 visits per calendar year combined	$7 Copay Covered up to 60 visits per calendar year combined		$20 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
Chiropractic Care (limited to 16 visits per calendar year)	$20 Copay	$20 Copay		$20 Copay	Deductible then 30% Coinsurance
Acupuncture (limited to 16 visits per calendar year)	$20 Copay	$20 Copay		$20 Copay	Deductible then 30% Coinsurance
Ambulance Services	Covered in Full	Covered in Full		Deductible then 20% 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.

Rx Cost Level Prescription Drugs - All Plans (through Express Scripts (ESI), 877-861-0376)	30 Day Supply		90 Day Supply	
	BMC Pharmacy	Other Pharmacy	BMC Mail Order/ Cornerstone	Mail Order/ ESI
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)

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