# Boston Medical Center

# Benefit Comparison 2024

| Plan | BMC Select | BMC Tiered HMO | | HPHC PPO | |
|---|---|---|---|---|---|
| **Benefit Comparison** | BMC Network | Tier 1<br>Core Network | Tier 2<br>High Cost Network | In-Network | Out-of-Network |
| **Network**<br>View provider directories at:<br>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<br>▪ Brigham and Women's Hospital<br>▪ Cape Cod Hospital<br>▪ Mass General Hospital<br>▪ UMass Memorial Medical Center | Local: Harvard Pilgrim Netowrk<br>Nationwide: United Health Network | All non-covered providers and hospitals |
| **Deductible** | N/A | N/A | N/A | $1,500 Individual<br>$3,000 Family | $2,000 Individual<br>$5,000 Family |
| **Out-of-Pocket Maximum** | $2,500 Individual per calendar year<br>$5,000 Family per calendar year | $3,000 Individual per calendar year<br>$6,000 Family per calendar year | | $3,000 Individual $6,000 Family<br>Annual In-network<br>out-of-pocket maximum | $3,000 Individual $6,000 Family<br>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**<br>(routine physical, immunizations) | Covered in Full | Covered in Full | | Covered in Full | Deductible then<br>30% Coinsurance |
| **Primary Care**<br>(Consultations, evaluations and sickness and injury) | $7 Copay | $25 Copay | | $50 Copay | Deductible then<br>30% Coinsurance |
| **Specialist Office Visits** | $7 Copay | $30 Copay | | $65 Copay | Deductible then<br>30% Coinsurance |
| **Emergency Admission for ER** | Covered in Full | Covered in Full | | Deductible then<br>20% Coinsurance | Deductible then<br>20% Coinsurance |
| **Inpatient Services** | | | | | |
| **Inpatient Hospital Services** | Covered in Full | $250 Copay per Admission | $1,000 Copay per Admission | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **Skilled Nursing Facility**<br>(up to 100 days per calendar year) | Covered in Full | Covered in Full | $1,000 Copay per Admission | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **Inpatient Rehabilitation**<br>(up to 60 days per calendar year) | Covered in Full | Covered in Full | $1,000 Copay per Admission | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **Hospital Outpatient** | | | | | |
| **Day Surgery** | Covered in Full | $100 copay per visit | $650 copay per visit | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **Laboratory Tests and X-rays** | Covered in Full | Covered in Full | | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **Chemotherapy/Radiation** | Covered in Full | Covered in Full | | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **High End Radiology**<br>**(CT/PET/MRI/MRA/NM)** | Covered in Full | Non Hospital Based $50 Copay<br>Hospital Based $100 Copay | $400 Copay | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **Maternity Services** | | | | | |
| **Prenatal and Postpartum Care** | Covered in Full | Covered in Full | | Covered in Full | Deductible then<br>30% Coinsurance |
| **All Hospital Services for Mother** | Covered in Full | $100 Copay per admission | $1,000 Copay per Admission | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **Routine Nursery Charges**<br>**for Newborn** | Covered in Full | Covered in Full | | Covered in Full | Deductible then<br>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<br>30% Coinsurance |

*Continued on reverse side* ▶

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| **Mental Health - Drug and Alcohol Rehabilitation** | | | | | |
| **Inpatient** | Covered in Full | Covered in Full | | Deductible then<br>20% Coinsurance | Deductible then<br>30% Coinsurance |
| **Outpatient Mental Health and Drug Alcohol Rehab** | $7 Copay | $7 Copay | | Individual: $50 Copay<br>Group: $10 Copay | Deductible then<br>30% Coinsurance |
| **Same Day Care Option** | | | | | |
| **Doctor on Demand**<br>(Telemedicine) | $7 Copay | $7 Copay | | $7 Copay | |
| **Convenience Care**<br>(ex: CVS Minute Clinic) | $7 Copay | $7 Copay | | $7 Copay | |
| **Urgent Care Stand Alone**<br>(non-hospital based) | $7 Copay | $7 Copay | | $7 Copay | |
| **Emergency Room Care** | $150 Copay | $150 Copay | | $150 Copay | |
| **Dental** | | | | | |
| **Preventive Pediatric Dental**<br>(children up to age 13) | $7 Copay | $ 7 Copay | | $50 Copay | Deductible then<br>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<br>30% Coinsurance |
| **Initial Emergency Treatment**<br>(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**<br>(combined benefit) | $7 Copay<br>Covered up to 60 visits per calendar year combined | $7 Copay<br>Covered up to 60 visits per calendar year combined | | $20 Copay<br>Covered up to 40 visits per calendar year combined in-network and out-of-network | Deductible then<br>30% Coinsurance<br>Covered up to 40 visits per calendar year combined in-network and out-of-network |
| **Chiropractic Care**<br>(limited to 16 visits per calendar year) | $20 Copay | $20 Copay | | $20 Copay | Deductible then<br>30% Coinsurance |
| **Acupuncture**<br>(limited to 16 visits per calendar year) | $20 Copay | $20 Copay | | $20 Copay | Deductible then<br>30% Coinsurance |
| **Ambulance Services** | Covered in Full | Covered in Full | | Deductible then 20% Coinsurance | |
| **Durable Medical Equipment** | 20% Coinsurance | 20% Coinsurance | | Deductible then<br>20% Coinsurance | Deductible then<br>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** | $7 | $20 | $14 | $40 |
| **Tier 2** | $15 | $40 | $30 | $80 |
| **Tier 3** | $25 | $80 | $75 | $240 |
| **Tier 4 (Specialty)** | $30 | 20% (up to $250) | $90 | 20% (up to $750) |

**Healthplansinc.com/bmc 844-926-2262**