City of Boston Non-Medicare Plan Comparison Chart (Effective July 1, 2020)

Covered Services	Blue Cross Elect Preferred PPO	Harvard Pilgrim HMO	AllWays Health Partners HMO
Network	In-Network/Out-of-Network	In-Network Only	In-Network Only
Monthly Rates	$410.80 Individual $1,014.00 Family	$178.23 Individual $479.83 Family	$148.59 Individual $393.90 Family
Service Area	Anywhere in United States*	Massachusetts-Based	Massachusetts-Based
Deductible *(per plan year)*	In-Network: $0 Out-of-Network: $250 per member, up to $750 per family	$0	$0
Out of Pocket Maximum			
In-Network *(applies to all out-of-pocket costs for covered medical and prescription drug services)*	$4,500 per member, up to $9,000 per family	$4,500 per member, up to $9,000 per family	$4,500 per member, up to $9,000 per family
Out-of-Network *(applies to co-insurance only)*	$4,500 per member, up to $9,000 per family	No Coverage	No Coverage
Preventive Care Visits, Health Screenings, and Immunization	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0
Office Visits Copays *(Non-Preventive)*	In-Network: $20 per primary care visit $30 per specialty care visit Out-of-Network: 20% co-insurance after deductible	$20 per primary care visit $30 per specialty care visit	$20 per primary care visit $30 per specialty care visit
Chiropractor Visit	In-Network: $30 copay Out-of-Network: 20% co-insurance after deductible	Not Covered	Not Covered
Physical Therapy	In-Network: $30 copay Out-of-Network: 20% co-insurance after deductible	$20 copay	$20 copay
	Up to 100 visits per plan year	Up to 60 visits per plan year	Up to 60 visits per plan year
Prescription Drugs *(must be purchased from participating pharmacies unless otherwise noted; no cost-sharing on birth control at Tier 1 only)*	Up to a 30-day supply at a retail pharmacy: Tier 1 – $10 copay Tier 2 – $30 copay Tier 3 – $55 copay	Up to a 30-day supply at a retail pharmacy: Tier 1 – $10 copay Tier 2 – $30 copay Tier 3 – $55 copay	Up to a 30-day supply at a retail pharmacy: Tier 1 – $10 copay Tier 2 – $30 copay Tier 3 – $55 copay
	Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – $20 copay Tier 2 – $60 copay Tier 3 – $135 copay	Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – $20 copay Tier 2 – $60 copay Tier 3 – $135 copay	Up to a 90-day supply at a Mail-order pharmacy: Tier 1 – $20 copay Tier 2 – $60 copay Tier 3 – $135 copay

All plan accumulators (out-of-pocket limits, therapy visits, etc.) will run on a plan year (July 1st – June 30th).

This comparison chart is not a comprehensive explanation of benefits. Please see the plan's Schedule of Benefits and/or Summary of Benefits for additional information.

Covered Services	Blue Care Elect Preferred PPO	Harvard Pilgrim HMO	AllWays Health Partners HMO
Diagnostic Test *(x-ray, blood work)*	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0
Imaging *(CT/PET scans, MRIs)*	In-Network: $50 copay* Out-of-Network: 20% co-insurance after deductible	$50 copay*	$50 copay*
Outpatient Hospital	In-Network: $50 copay* Out-of-Network: 20% co-insurance after deductible	$50 copay*	$50 copay*
Inpatient Hospital and Skilled Nursing Care	In-Network: $50 copay* Out-of-Network: 20% co-insurance after deductible	$50 copay*	$50 copay*
Behavioral Health Services (Mental Health or Substance Use Disorder)	Outpatient services: $20 copay Inpatient services: $0 Out-of-Network: 20% co-insurance after deductible	Outpatient services: $20 copay Inpatient services: $0	Outpatient services: $20 copay Inpatient services: $0
Emergency Room Care	$100 copay per visit, waived if admitted to hospital	$100 copay per visit, waived if admitted to hospital	$100 copay per visit, waived if admitted to hospital
Emergency Medical Transportation	$0	$0	$0
Home Health Care	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0
Durable Medical Equipment	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$0	$0
Routine Vision Care	In-Network: $0 Out-of-Network: 20% co-insurance after deductible	$20 copay	$30 copay
	Once every 24 months (In- & Out-of-Network combined)	Once per plan year	Once every 12 months
Preventative Dental Care	Not covered	Up to Age 13 – $0 Age 13 and over - $20 Two visits per plan year	Up to Age 12 – $0 One visit every six months

*Maximum of one copayment per service type per member per plan year.

All plan accumulators (out-of-pocket limits, therapy visits, etc.) will run on a plan year (July 1st – June 30th).

This comparison chart is not a comprehensive explanation of benefits. Please see the plan's Schedule of Benefits and/or Summary of Benefits for additional information.