

City of Boston Non-Medicare Plan Comparison Chart (Effective July 1, 2021)

Covered Services	AllWays Value HMO	BCBS Standard HMO <i>(Network Blue New England)</i>	BCBS PPO <i>(Blue Care Elect Preferred)</i>
Network	In-Network	In-Network Only	In-Network/Out-of-Network
Monthly Rates	\$154.57 individual \$409.76 family	\$186.29 Individual \$493.61 Family	\$346.45 Individual \$918.06 Family
Service Area	Massachusetts-based	New England-Based	Anywhere in United States
Deductible <i>(per plan year)</i>	\$0	\$100 per member, up to \$200 per family	In-Network: \$250 per member, up to \$500 per family
			Out-of-Network: \$350 per member, up to \$875 per family
Out of Pocket Maximum			
In-Network <i>(applies to all out-of-pocket costs for covered medical and prescription drug services)</i>	\$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 <i>(applies to deductible and co-insurance)</i>	No Coverage	No Coverage	\$4,500 per member, up to \$9,000 per family
Preventive Care Visits, Health Screenings, and Immunization	\$0	\$0	In-Network: \$0
			Out-of-Network: 20% co-insurance after deductible
Office Visit Copays <i>(Non-Preventive)</i>	\$20 per primary care visit \$30 per specialty care visit	\$20 per primary care visit \$35 per specialty care visit	In-Network: \$20 per primary care visit \$35 per specialty care visit
			Out-of-Network: 20% co-insurance after deductible
Chiropractor Visit	Not Covered	Not Covered	In-Network: \$35 copay
			Out-of-Network: 20% co-insurance after deductible
Physical Therapy	\$20 copay	\$20 copay	In-Network: \$20 copay
			Out-of-Network: 20% co-insurance after deductible
	Up to 60 visits per plan year	Up to 60 visits per plan year	Up to 100 visits per plan year
Prescription Drugs <i>(must be purchased from participating pharmacies unless otherwise noted; no cost-sharing on birth control at Tier 1 only)</i>	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, deductibles, 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	AllWays Value HMO	BCBS Standard HMO <i>(Network Blue New England)</i>	BCBS PPO <i>(Blue Care Elect Preferred)</i>
Diagnostic Test <i>(X-ray, blood work)</i>	\$0	\$0 after deductible	In-Network: \$0 after deductible ----- Out-of-Network: 20% co-insurance after deductible
Advanced Imaging <i>(CT/PET scans, MRIs)</i>	\$50 copay*	\$100 copay after deductible*	In-Network: \$100 copay after deductible* ----- Out-of-Network: 20% co-insurance after deductible
Outpatient Hospital	\$50 copay*	\$100 copay after deductible*	In-Network: \$100 copay after deductible* ----- Out-of-Network: 20% co-insurance after deductible
Inpatient Hospital and Skilled Nursing Care	\$50 copay*	\$100 copay after deductible*	In-Network: \$100 copay after deductible* ----- Out-of-Network: 20% co-insurance after deductible
Behavioral Health Services <i>(Mental Health or Substance Use Disorder)</i>	Outpatient services: \$20 copay	Outpatient services: \$20 copay	Outpatient services: \$20 copay
	Inpatient services: \$0	Inpatient services: \$0	Inpatient services: \$0 ----- Out-of-Network: 20% co-insurance after deductible
Emergency Room Care	\$100 copay per visit, waived if admitted to hospital	\$100 copay after deductible, waived if admitted to hospital	\$100 copay after deductible, waived if admitted to hospital
Emergency Medical Transportation	\$0	\$0 after deductible	\$0 after deductible
Home Health Care	\$0	\$0 after deductible	In-Network: \$0 after deductible ----- Out-of-Network: 20% co-insurance after deductible
Durable Medical Equipment	\$0	\$0 after deductible	In-Network: \$0 after deductible ----- Out-of-Network: 20% co-insurance after deductible
Routine Vision Care	\$30 copay	\$20 copay	In-Network: \$0 ----- Out-of-Network: 20% co-insurance after deductible
	Once every 12 months	Once per plan year	Once every 24 months (In- & Out-of-Network combined)
Preventative Dental Care	Up to Age 12 – \$0	Up to Age 13 – \$0	Not Covered
	1 visit every 6 months	2 visits per plan year	

* Maximum of one copayment per category (Advanced Imaging, Outpatient Hospital, and Inpatient Hospital) per plan year.

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