Boston Medical Center HealthNet Plan

Benefit Comparison 2018

Plan	Focus MA HMO	HMO with HRA	PPO with HSA	
Benefit Comparison	In-Network	In-Network	In-Network	Out-of-Network
Deductible	Not Applicable	$1,500 Individual per plan year $3,000 Family per plan year	$1,500 Individual per plan year/$3,000 Family per plan year (Combined In-Network and Out-of-Network Deductible)	
Member Out-of-Pocket Maximum (Includes all member cost sharing; ie Medical Copays, Deductibles, Coinsurance, and Rx Copays)	$1,000 Individual per plan year $2,000 Family per plan year	$3,000 Individual per plan year $6,000 Family per plan year	$3,000 Individual per plan year $6,000 Family per plan year (Combined In-Network and Out-of-Network Out of Pocket Maximum)	$3,000 Individual per plan year $6,000 Family per plan year (Combined In-Network and Out-of-Network Out of Pocket Maximum) Any applicable copayment amounts, and any charges in excess of usual and customary do not apply towards the annual out-of-pocket maximum.
Special Note	For the **HMO with HRA**, no one member of a family will pay more than the per member deductible. For family coverage under the **PPO with HSA**, the entire family deductible must be met before any non-preventive benefits are paid for any family member.			
Enrollment Area	**MA (plus some bordering towns)**	MA, NH, ME, RI, CT	Nationwide	
Which network to use? Check www.hphc.org/providerdirectory	**Focus Network MA (under Tiered/Limited Plans)**	HMO (under Stardard Plans)	PPO (under Stardard Plans)	
Flexible Spending Account (FSA)	Employees are eligible to contribute	Employees are eligible to contribute	Not Applicable	
Health Reimbursement Account (HRA)	Not Applicable	Employer contributes $750 Individual and $1,500 Family	Not Applicable	
Health Savings Account (HSA)	Not Applicable	Not Applicable	Employer contributes $750 Individual and $1,500 Family allocated quarterly. Employees are eligible to contribute an additional $2,700 / $5,400 in additional contributions. The limits increased to $3450 and $6900 for 2018.	
Physician Services				
Preventive Primary Care (routine physical, immunizations)	Covered in Full	Covered in Full	Covered in Full	Deductible, then 20% Coinsurance
Primary Care (Consultations, evaluations and sickness and injury)	$25 copay	$25 copay	Deductible, then no charge	Deductible, then 20% Coinsurance
Specialist Office Visits	$40 Copay	$40 Copay	Deductible, then no charge	Deductible, then 20% Coinsurance
Doctor On-Demand (Telemedicine)	$25 copay	$25 copay	Deductible, then no charge	N/A
Urgent Care	$25 copay	$25 copay	Deductible, then no charge	Deductible, then 20% Coinsurance
Infertility Services	Cost sharing is dependent upon type of service provided	Cost sharing is dependent upon type of service provided	Deductible, then no charge	Deductible, then 20% Coinsurance
Emergency Room Care	$150 Copay	$150 Copay	Deductible, then no charge	
Inpatient Services				
Inpatient Hospital Services	$250 copay	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Skilled Nursing Facility (up to 100 days per plan year)	$250 copay	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Inpatient Rehabilitation (up to 60 days per plan year)	$250 copay	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospital Outpatient				
Day Surgery	$150 copay	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Laboratory Tests and X-rays	Covered in Full	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Chemotherapy/Radiation	Covered in Full	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
High End Radiology (CT/PET/MRI/MRA/NM)	$150 copay	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Maternity Services				
Routine Outpatient Prenatal and Postpartum Care	Covered in Full	Covered in Full	Covered in Full	Deductible, then 20% Coinsurance
Inpatient Maternity Care	$250 copay	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance

Harvard Pilgrim Health Care

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Boston Medical Center HealthNet Plan
Benefit Comparison 2018

Plan	Tiered HMO		HMO with HRA		PPO with HSA	
Benefit Comparison	In-Network		In-Network		In-Network	Out-of-Network
Mental Health - Drug and Alcohol Rehabilitation						
Inpatient	$250 copay		Deductible, then no charge		Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient Mental Health	$25 Copay		$25 Copay		Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient Drug Alcohol Rehab	$25 Copay		$25 Copay		Deductible, then no charge	Deductible, then 20% Coinsurance
Dental						
Preventive Pediatric Dental (children up to age 13)	$25 Copay		$25 Copay		$25 copay	Deductible, then 20% 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		Deductible, then no charge	Deductible, then 20% 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		Deductible, then no charge	Deductible, then 20% Coinsurance
Other Health Services						
Physical and Occupational Therapy	$25 Copay		Deductible, then no charge		Deductible, then no charge	Deductible, then 20% Coinsurance
	PT = Max 60 visits per plan year OT = Max 60 visits per plan year		PT = Max 60 visits per plan year OT = Max 60 visits per plan year		PT = Max 60 visits per plan year OT = Max 60 visits per plan year In-network and Out-of-network	
Chiropractic Care (unlimited per plan year)	$25 Copay		$25 Copay		Deductible, then no charge	Deductible, then 20% Coinsurance
Acupuncture (20 visits per plan year)	$40 copay		$40 copay		Deductible, then no charge	Deductible, then 20% Coinsurance
Ambulance Services	$100 copay		Deductible, then no charge		Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment	20% Coinsurance		Deductible, then 20% Coinsurance		Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Prescription Drugs						
	30 Day Supply (Retail)	**90 Day Supply (Mail-Order)**	**30 Day Supply (Retail)**	**90 Day Supply (Mail-Order)**	**30 Day Supply (Retail)**	**90 Day Supply (Mail-Order)**
Tier 1	$15	$15	$15	$15	$15 (after deductible is met)	$15 (after deductible is met)
Tier 2	$30	$30	$30	$30	$30 (after deductible is met)	$30 (after deductible is met)
Tier 3	$50	$50	$50	$50	$50 (after deductible is met)	$50 (after deductible is met)
Tier 4	$100	$100	$100	$100	$100 (after deductible is met)	$100 (after deductible is met)

This is intended to be a summary only; please refer to the *Schedule of Benefits* for detailed information available **at www.hphc.org/bmchp** or by calling **(888) 333-4742**

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