2023 Medical Plan Highlight Chart

Boston Children's Hospital

		Network Blue New England Value HMO		Network Blue New England Premium HMO		Blue Care Elect Preferred PPO	
		In-Network Benefits		In-Network Benefits		In-Network Benefits	Out-of-Network Benefits
Overall Member Cost Share Provisions		**Preferred Network**	**Standard Network**	**Preferred Network**	**Standard Network**		
Deductible (medical benefits) – There is a separate deductible for services provided in the Preferred Network & the Standard Network		$750 per member/ Preferred Network	$750 per member/ Standard Network	$250 per member/ Preferred Network	$250 per member/ Standard Network	$250 per member	$500 per member
		$1,500 per family/ Preferred Network	$1,500 per family/ Standard Network	$500 per family Preferred Network	$500 per family/ Standard Network	$500 per family	$1,000 per family
Out-of-Pocket Maximum (medical benefits)		$2,000 per member		$2,000 per member		$2,000 per member	
		$4,000 per family		$4,000 per family		$4,000 per family	
		This out-of-pocket maximum is a total of the deductible, copayments, and coinsurance you pay for all medical benefits, excluding costs for prescription drug benefits.		*This out-of-pocket maximum is a total of the deductible, copayments, and coinsurance you pay for all medical benefits, excluding costs for prescription drug benefits.*		*This out-of-pocket maximum is a total of the deductible, copayments, and coinsurance you pay for all medical benefits, excluding costs for prescription drug benefits.*	
Overall Benefit Maximum		None		None		None	
Covered Services		**Your Cost is:**	**Your Cost is:**	**Your Cost is:**	**Your Cost is:**	**Your Cost Is:**	**Your Cost Is:**
Admissions for Inpatient Medical and Surgical Care	In a General Hospital	10% coinsurance after deductible	20% coinsurance after deductible	$250 copayment per admission after deductible	$250 copayment per admission; then 10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible
	In a Chronic Disease Hospital	10% coinsurance after deductible	20% coinsurance after deductible	$250 copayment per admission after deductible	$250 copayment per admission; then 10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible
	In a Rehabilitation Hospital *(60 day benefit limit per member per calendar year)*	10% coinsurance after deductible up to benefit limit; then you pay all costs	20% coinsurance after deductible up to benefit limit; then you pay all costs	$250 copayment per admission after deductible	$250 copayment per admission; then 10% coinsurance after deductible	10% coinsurance after deductible; up to benefit limit then you pay all costs	30% coinsurance after deductible; up to benefit limit then you pay all costs
	In a Skilled Nursing Facility *(100 day benefit limit per member per calendar year)*	10% coinsurance after deductible up to benefit limit; then you pay all costs	20% coinsurance after deductible up to benefit limit; then you pay all costs	$250 copayment per admission after deductible	$250 copayment per admission; then 10% coinsurance after deductible	10% coinsurance after deductible; up to benefit limit then you pay all costs	30% coinsurance after deductible; up to benefit limit then you pay all costs
Ambulance Services	Emergency Ambulance	10% coinsurance after deductible	10% coinsurance after deductible	No charge (deductible does not apply)	No charge (deductible does not apply)	No charge (deductible does not apply)	No charge (deductible does not apply)
	Other Ambulance	10% coinsurance after deductible	10% coinsurance after deductible	No charge (deductible does not apply)	No charge (deductible does not apply)	No charge (deductible does not apply)	30% coinsurance after deductible
Chiropractic Services	Outpatient Medical Care Services, including spinal manipulation	$40 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	30% coinsurance after deductible
Durable Medical Equipment	Covered medical equipment rented or purchased for home use	10% coinsurance after deductible (no charge for one breast pump per birth, excluding hospital grade pumps)	10% coinsurance after deductible (no charge for one breast pump per birth, excluding hospital grade pumps)	No charge after deductible	No charge after deductible	10% coinsurance after deductible	30% coinsurance after deductible
Emergency Medical Outpatient Services	Emergency Room Services	10% coinsurance after deductible		$150 copayment per visit (deductible does not apply)		$150 copayment per visit (deductible does not apply)	
				The emergency room copayment is waived if the visit results in your being held for an overnight observation stay or being admitted for inpatient care within 24 hours.			
	Primary care provider, OB/GYN physician, nurse practitioner, physician assistant, and nurse midwife services	$25 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$25 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$25 copayment per visit (deductible does not apply)	30% coinsurance after deductible
	Other covered provider services	$40 copayment per visit (deductible does not apply)		$40 copayment per visit (deductible does not apply)		$40 copayment per visit (deductible does not apply)	30% coinsurance after deductible
Home Health Care	Home Care Program	10% coinsurance after deductible	10% coinsurance after deductible	No charge after deductible	No charge after deductible	10% coinsurance after deductible	30% coinsurance after deductible
Lab Tests, X-Rays, and Other Tests	Outpatient Lab Tests	10% coinsurance after deductible	20% coinsurance after deductible	No charge after deductible	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible
	Outpatient CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	10% coinsurance after deductible	20% coinsurance after deductible	$100 copayment after deductible per category of test per service date for hospital services; otherwise, you pay nothing	$100 copayment after deductible per category of test per service date for hospital services; then 10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
	Other outpatient tests and preoperative tests	10% coinsurance after deductible	20% coinsurance after deductible	No charge after deductible	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible

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Overall Member Cost Share Provisions		**Preferred Network**	**Standard Network**	**Preferred Network**	**Standard Network**		
Covered Services		**Your Cost is:**	**Your Cost is:**	**Your Cost is:**	**Your Cost is:**	**Your Cost Is:**	**Your Cost Is:**
Maternity Services & Well Newborn Inpatient Care	Maternity Services (includes delivery and postnatal care)	10% coinsurance after deductible	20% coinsurance after deductible	$250 copayment per admission after deductible for inpatient hospital services; otherwise, you pay nothing	$250 copayment per admission after deductible for inpatient hospital services; then 10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
	Prenatal Care	No charge (deductible does not apply)		No charge (deductible does not apply)		No charge (deductible does not apply)	30% coinsurance after deductible
	Well newborn care during enrolled mother's maternity admission	No charge (deductible does not apply)		No charge (deductible does not apply)		No charge (deductible does not apply)	30% coinsurance (deductible does not apply)
Medical Care Outpatient Visits	Primary care provider, OB/GYN physician, nurse practitioner, physician assistant and nurse midwife services	$25 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$25 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$25 copayment per visit (deductible does not apply)	30% coinsurance after deductible
	Other covered provider services	$40 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$40 copayment per (deductible does not apply)	$40 copayment per (deductible does not apply)	$40 copayment per visit (deductible does not apply)	30% coinsurance after deductible
	Telehealth Visit	$25 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$25 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$25 copayment per visit (deductible does not apply)	30% coinsurance after deductible
Mental Health & Substance Abuse	Inpatient admissions in a General or Mental Hospital or Substance Abuse Facility	10% coinsurance after deductible	20% coinsurance after deductible	$250 copayment per admission after deductible for inpatient hospital services; otherwise, you pay nothing	$250 copayment per admission after deductible for inpatient hospital services; then 10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
	Outpatient Services	No copayment for first 6 visits; $25 copayment for subsequent visits (deductible does not apply); or no charge for hospital services after deductible	No copayment for first 6 visits; $25 copayment for subsequent visits (deductible does not apply); or no charge for hospital services after deductible	No copayment for first 6 visits; $25 copayment for subsequent visits (deductible does not apply); or no charge for hospital services after deductible	No copayment for first 6 visits; $25 copayment for subsequent visits (deductible does not apply); or no charge for hospital services after deductible	No copayment for first 6 visits; $25 copayment for subsequent visits (deductible does not apply)	30% coinsurance after deductible
Preventive Health Services	Routine Pediatric Care	No charge (deductible does not apply)		No charge (deductible does not apply)		No charge (deductible does not apply)	30% coinsurance after deductible
	Routine Adult Exams & Tests	No charge (deductible does not apply)		No charge (deductible does not apply)		No charge (deductible does not apply)	30% coinsurance after deductible
	Routine GYN Exams *(once per member per calendar year)*	No charge (deductible does not apply)		No charge (deductible does not apply)		No charge (deductible does not apply)	30% coinsurance after deductible
	Family Planning	No charge (deductible does not apply)		No charge (deductible does not apply)		No charge (deductible does not apply)	30% coinsurance after deductible
	Routine Hearing Exams	No charge (deductible does not apply)		No charge (deductible does not apply)		No charge (deductible does not apply)	30% coinsurance after deductible
	Hearing Aids/Related Services	No charge up to $2,000 per ear every 36 months for members age 21 or younger; then, you pay all costs		No charge up to $2,000 per ear every 36 months for members age 21 or younger; then, you pay all costs		No charge up to $2,000 per ear every 36 months for members age 21 or younger; then, you pay all costs	
	Routine Vision Exams *(one exam per member per calendar year)*	No charge (deductible does not apply)		No charge (deductible does not apply)		No charge (deductible does not apply)	30% coinsurance after deductible for a covered exam; otherwise, you pay all costs
Prosthetic Devices	Ostomy Supplies	No charge after deductible		No charge after deductible		10% coinsurance after deductible	30% coinsurance after deductible
	Artificial limb devices (includes repairs) and other external prosthetic devices	10% coinsurance after deductible	10% coinsurance after deductible	No charge after deductible	No charge after deductible	10% coinsurance after deductible	30% coinsurance after deductible
Short-Term Rehabilitation Therapy	Outpatient physical, occupational, and speech therapy	$40 copayment per visit for covered services (deductible does not apply); otherwise, you pay all costs		$40 copayment per visit for covered services (deductible does not apply); otherwise, you pay all costs		$40 copayment per visit for covered services (deductible does not apply); otherwise, you pay all costs	30% coinsurance after deductible
		(60-visit benefit limit per member per calendar year)*		*(60-visit benefit limit per member per calendar year*)*		*(100-visit benefit limit for per member per calendar year*)*	
		**Benefit limit does not apply for: speech therapy; and when any of these covered services are furnished to treat autism spectrum disorders or as part of covered home health care.*					
Surgery as an Outpatient	Outpatient day surgery at a surgical day care unit of hospital, ambulatory surgical facility, or hospital outpatient department	10% coinsurance after deductible	20% coinsurance after deductible	$150 copayment per admission after deductible	$150 copayment per admission after deductible; then 10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
	Primary care provider, OB/GYN physician, nurse practitioner, physician assistant and nurse midwife services	$25 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$25 copayment per visit (deductible does not apply)	$40 copayment per visit (deductible does not apply)	$25 copayment per visit (deductible does not apply)	30% coinsurance after deductible
	Other covered provider services	$40 copayment (deductible does not apply)	$40 copayment (deductible does not apply)	$40 copayment (deductible does not apply)	$40 copayment (deductible does not apply)	$40 copayment per visit	30% coinsurance after deductible

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Overall Member Cost Share Provisions	**Preferred Network**	**Standard Network**	**Preferred Network**	**Standard Network**		
Covered Services	**Your Cost is:**	**Your Cost is:**	**Your Cost is:**	**Your Cost is:**	**Your Cost Is:**	**Your Cost Is:**
Prescription Drugs Administered through CVS / Caremark						
Out-of-Pocket Maximum (pharmacy benefits)	$5,000 per member / $10,000 per family (Copays apply to the prescription out-of-pocket maximum)		$5,000 per member / $10,000 per family (Copays apply to the prescription out-of-pocket maximum)		$5,000 per member / $10,000 per family (Copays apply to the prescription out-of-pocket maximum)	
Generic Drugs	In-Network 30 day supply: $10 90 day supply: $25 Out-of-Network 30 day supply: $10 90 day supply: *		In-Network 30 day supply: $10 90 day supply: $25 Out-of-Network 30 day supply: $10 90 day supply: *		30 day supply: $10 90 day supply: $25	30 day supply: $10 90 day supply: *
Preferred Brand Drugs	In-Network 30 day supply: $30 90 day supply: $75 Out-of-Network 30 day supply: $30 90 day supply: *		In-Network 30 day supply: $30 90 day supply: $75 Out-of-Network 30 day supply: $30 90 day supply: *		30 day supply: $30 90 day supply: $75	30 day supply: $30 90 day supply: *
Non-Preferred Brand Drugs	In-Network 30 day supply: $50 90 day supply: $150 Out-of-Network 30 day supply: $50 90 day supply: *		In-Network 30 day supply: $50 90 day supply: $150 Out-of-Network 30 day supply: $50 90 day supply: *		30 day supply: $50 90 day supply: $150	30 day supply: $50 90 day supply: *
Specialty	Coverage under above categories (no coverage for out-of-network mail order claims). Copay Assistance may apply as appropriate**		Coverage under above categories (no coverage for out-of-network mail order claims). Copay Assistance may apply as appropriate**		Coverage under above categories (no coverage for out-of-network mail order claims). Copay Assistance may apply as appropriate**	
Limitations & Exceptions	* Out-of-Network claims can be reimbursed in full less copayment, if member submits a paper claim after the fact (members pay out of pocket in full at the point of sale). No coverage for out-of-network mail order – only 90 days at CVS ** Any manufacturer dollars applied will not apply toward the annual out-of-pocket maximum. Your out-of-pocket cost per 30 day supply will not exceed your plan's set cost-sharing shown above.					
Any maintenance medications (more than a 30-day supply) must be filled at a CVS Pharmacy or by mail order.						
Important notes about all three medical plans with BCBSMA						
• Both HMO Plans require you to have a primary care physician (PCP) on file with BCBSMA. At the time you enroll in either of the HMO health plans, you will be required to choose (or designate) a primary care provider who participates in your health care network and who is available to accept you or your family members. You have the right to choose (or designate) any primary care provider who participates in your health care network and who is available to accept you or your family members.						
• Both HMO Plans require you to receive a referral from your PCP to see specialists, except for obstetrical or gynecological care.						