CITY OF WORCESTER — NEWLY SETTLED BENEFIT SUMMARY — JULY 1, 2024

BENEFIT	HPHC FOCUS	BCBS NETWORK BLUE SELECT	HPHC CHOICENET	BCBS NETWORK BLUE NEW ENGLAND	BCBS BLUE CARE ELECT PREFERRED (FOR THOSE RESIDING OUTSIDE NEW ENGLAND ONLY)	
					IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE	$400 IND/$800 FAM	$500 IND/$1,000 FAM	$500 IND/$1,000 FAM	$500 IND/$1,000 FAM	$500 IND/$1,000 FAM	
OUT OF POCKET MAXIMUM (INDIVIDUAL/FAMILY)	$5,000/$10,000 MED $2,000/$4,000 RX	$5,000/$10,000 MED $2,000/$4,000 RX	$5,000/$10,000 MED $2,000/$4,000 RX	$5,000/$10,000 MED $2,000/$4,000 RX	$5,000/$10,000 MED $2,000/$4,000 RX	
WELLNESS VISIT	$0	$0	$0	$0	$0	20% co-insurance (after deductible)
PCP OFFICE VISIT	$20 co-pay	$25 co-pay	T1: $20 | T2/T3: $25	T1: $20 | T2: $30 | T3: $40	$40 co-pay	20% co-insurance (after deductible)
SPECIALIST VISIT	$35 co-pay	$50 co-pay	T1: $40 | T2/T3: $50	$50 co-pay	$50 co-pay	20% co-insurance (after deductible)
PRESCRIPTIONS	Retail: $10/$30/$60 (30 day supply) | Mail Order: $25/$75/$180 (90 day supply)** (All Plans)					
INPATIENT HOSPITAL	$275 co-pay (after deductible)	$500 co-pay (after deductible)	T1: $275 | T2: $500 | T3: $750 (after deductible)	T1: $275 | T2: $750 ($800 Select, no deductible) | T3: $1,000 (after deductible)	10% co-insurance (after deductible)	30% co-insurance (after deductible)
OUTPATIENT SURGERY	$250 co-pay (after deductible)	$350 co-pay (after deductible)	T1: $250 | T2: $350 | T3: $500 (after deductible)	Surgical day care facility: T1: $250 | T2: $500 ($550 Select, no deductible) | T3: $750 Ambulatory surgical facility: $250 (after deductible)	Office setting: $50 | Ambulatory surgical facility: $500 per admit (after deductible)	20% co-insurance (after deductible)
DIAGNOSTIC SERVICES LAB, X-RAY, ETC.	Covered in full (after deductible)	Covered in full (after deductible)	Covered in full (after deductible)	Covered in full (after deductible)	10% co-insurance (after deductible)	30% co-insurance (after deductible)
CT SCAN, MRI, PET	$100 co-pay (after deductible)	$50 non-hospital | $100 hospital (after deductible)	$100 co-pay (after deductible)	$100 non-hospital | T1: $100 | T2: $250 | T3: $500 hospital (after deductible)	10% co-insurance (after deductible)	30% co-insurance (after deductible)
SHORT-TERM REHAB: OUTPATIENT/OT/PT	$20 co-pay (after deductible) Up to 60 combined visits per plan year	$25 co-pay (after deductible) Up to 60 combined visits per plan year	$25 co-pay (after deductible) Up to 60 combined visits per plan year	$50 co-pay Up to 60 combined visits per plan year	$50 co-pay (after deductible) 100 visits per plan year	20% co-pay (after deductible) 100 visits per plan year
SKILLED NURSING	Covered in full (after deductible) Up to 100 days per plan year	Covered in full (after deductible) Up to 100 days per plan year	Covered in full (after deductible) Up to 100 days per plan year	Covered in full Up to 100 days per plan year	10% co-insurance (after deductible) Up to 100 days per plan year	30% co-insurance (after deductible) Up to 100 days per plan year
CHIROPRACTOR	$20 co-pay 12 visits per plan year	$25 co-pay 12 visits per plan year	$25 co-pay 12 visits per plan year	$50 co-pay 12 visits per plan year	$50 co-pay	20% co-insurance (after deductible)
OUTPATIENT MENTAL HEALTH	$20 co-pay	$25 co-pay	$25 co-pay	$20 co-pay	$40 co-pay	20% co-insurance (after deductible)
DURABLE MEDICAL EQUIPMENT: WHEELCHAIRS/CRUSTCHES/ETC	20% co-insurance (after deductible)	20% co-insurance (after deductible)	20% co-insurance (after deductible)	20% co-insurance	20% co-insurance	40% co-insurance (after deductible)
ER VISIT (WAIVED IT ADMITTED)	$150 co-pay	$150 co-pay	$150 co-pay	$150 co-pay	$150 co-pay	$150 co-pay
AMBULANCE	Covered in full if medically necessary or when ordered by a physician (after deductible)	Covered in full if medically necessary or when ordered by a physician (after deductible)	Covered in full if medically necessary or when ordered by a physician (after deductible)	Covered in full if medically necessary or when ordered by a physician (no deductible)	Emergency: 10% co-insurance (no deductible) | Medically necessary: 10% co-insurance (after deductible)	Emergency: 10% co-insurance (no deductible) | Medically necessary: 30% co-insurance (after deductible)
PREMIUM RATES						
MONTHLY (IND/FAM)	$718.30 / $1,804.43	$867.99 / $2,155.03	$943.64 / $2,342.86	$1,072.34 / $2,772.36	$1,230.92 / $3,182.73	
EMPLOYEE COST						
WEEKLY (IND/FAM)	$41.44 / $104.10	$50.08 / $124.33	$54.44 / $135.17	$61.87 / $159.94	$71.01 / $183.62	
BI-WEEKLY (IND/FAM)	$82.88 / $208.20	$100.15 / $248.66	$108.88 / $270.33	$123.73 / $319.89	$142.03 / $367.24	
MONTHLY (IND/FAM)	$179.58 / $451.11	$217.00 / $538.76	$235.91 / $585.72	$268.09 / $693.09	$307.73 / $795.68	

*This is a brief summary of some of the benefits offered. Additional details can be found in the complete plan descriptions.
**Mandatory mail-away for maintenance drugs, or 90-day at retail for maintenance drugs; however, only allowed at CVS pharmacies