

CITY OF WORCESTER		BENEFIT SUMMARY			JULY 1, 2025	
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)	\$750.33 / \$1,884.90	\$934.83 / \$2,320.97	\$1,004.51 / \$2,493.98	\$1,154.91 / \$2,985.84	\$1,285.82 / \$3,324.68	
EMPLOYEE COST						
WEEKLY (IND/FAM)	\$43.29 / \$108.74	\$53.93 / \$133.90	\$57.95 / \$143.88	\$66.63 / \$172.26	\$74.18 / \$191.81	
BI-WEEKLY (IND/FAM)	\$86.58 / \$217.49	\$107.87 / \$267.80	\$115.91 / \$287.77	\$133.26 / \$344.52	\$148.36 / \$383.62	
MONTHLY (IND/FAM)	\$187.58 / \$471.23	\$233.71 / \$580.24	\$251.13 / \$623.50	\$288.73 / \$746.46	\$321.46 / \$831.17	

*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

BENEFIT	HPHC BEST BUY TIERED CO-PAY WITH HSA (BROAD NETWORK)
DEDUCTIBLE	\$2,000 IND/\$4,000 FAM UNDER THE QHDP, THE CITY WILL CONTINUE CONTRIBUTING HALF OF YOUR DEDUCTIBLE LEVEL TO YOUR HSA ACCOUNT EACH PLAN YEAR (HSA ENROLLMENT REQUIRED)
OUT OF POCKET MAXIMUM (INDIVIDUAL/FAMILY)	\$5,000 IND/\$10,000 FAM
WELLNESS VISIT	\$0
PCP OFFICE VISIT	\$20 co-pay (per visit after deductible)
SPECIALIST VISIT	\$40 co-pay (per visit after deductible)
PRESCRIPTIONS	Retail 30 Day Supply: \$10/\$30/\$60 (after deductible) Mail Order 90 Day Supply: \$25/\$75/\$180 (after deductible) Deductible waived for certain preventative drugs
INPATIENT HOSPITAL	\$275 co-pay (after deductible)
OUTPATIENT SURGERY	\$250 co-pay (after deductible)
DIAGNOSTIC SERVICES LAB, X-RAY, ETC.	Covered in full (after deductible)
CT SCAN, MRI, PET	\$50 non-hospital \$100 hospital (after deductible)
SHORT-TERM REHAB: OUTPATIENT/OT/PT	\$25 co-pay (after deductible) Up to 60 combined visits per plan year
SKILLED NURSING	Covered in full (after deductible) Up to 100 days per plan year
CHIROPRACTOR	\$25 co-pay after deductible 12 visits per plan year
OUTPATIENT MENTAL HEALTH	\$20 co-pay (after deductible)
DURABLE MEDICAL EQUIPMENT: WHEELCHAIRS/CRUSTCHES/ETC	20% co-insurance (after deductible)
ER VISIT (WAIVED IT ADMITTED)	\$150 co-pay (after deductible)
AMBULANCE	Covered in full when ordered by a Physician (after deductible)
PREMIUM RATES MONTHLY (IND/FAM)	 \$664.18 / \$1,649.03
EMPLOYEE COST WEEKLY (IND/FAM)	 \$38.32 / \$95.14
BI-WEEKLY (IND/FAM)	\$76.64 / \$190.27
MONTHLY (IND/FAM)	\$166.05 / \$412.26

*This is a brief summary of some of the benefits offered. Additional details can be found in the complete plan descriptions.

**Eligibility regulations must be met in order to enroll in this plan