

**City of Newton Benefit Comparison Chart**

**AFSCME 1703 (Engineers), AFSCME 2443 (Foreman), AFSCME 2913 (PCO), IAFF 863 Firefighters, MA Nurses Association,  
Newton Police Association, Newton Police Superior Officers Association and Teamsters Local 25  
July 1, 2023 - June 30, 2024 Plan Year**

	<b>Blue Cross Blue Shield Network Blue New England (HMO)</b>	<b>Blue Cross Blue Shield Blue Care Elect (PPO)</b>	
<b>Website</b>	<a href="http://www.bluecrossma.org">www.bluecrossma.org</a>		
<b>Member Service Number</b>	<b>1-800-782-3675</b>		
<b>Out of Pocket Maximum Individual/Family</b>	\$1,000 individual/\$2,500 family per plan year	\$1,000 individual/\$2,500 family per plan year	
<b>Fiscal Year Deductible Individual/Family</b>	\$250 individual/ \$500 family per plan year	\$250 individual/ \$500 family per plan year	
		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Primary Care Provider Office Visit</b>	\$25 copay Deductible does not apply	\$25 copay Deductible does not apply	20% Coinsurance
<b>Preventative Services</b>	No copay Deductible does not apply	No copay Deductible does not apply	20% Coinsurance
<b>Specialist Physician Office</b>	\$40 copay Deductible does not apply	\$40 copay Deductible does not apply	20% Coinsurance
<b>Retail Clinic/Limited Service Clinic</b>	\$5 copay Deductible does not apply	\$5 copay Deductible does not apply	20% Coinsurance
<b>Urgent Care Center</b>	\$10 copay Deductible does not apply	\$10 copay Deductible does not apply	20% Coinsurance
<b>Outpatient Behavioral Health &amp; Substance Use Disorder Care</b>	\$25 copay Deductible does not apply	\$25 copay Deductible does not apply	20% Coinsurance
<b>Emergency Room Care</b>	\$100 copay Deductible does not apply	\$100 copay Deductible does not apply	20% Coinsurance
<b>Inpatient Hospital Care - Medical</b>	No copay, deductible applies	No copay, deductible applies	20% Coinsurance
<b>Maternity Benefits</b>	No copay for routine visits. Deductible does not apply. Hospitalization deductible applies.	No copay for routine visits. Deductible does not apply. Hospitalization deductible applies.	20% Coinsurance
<b>Outpatient Surgery</b>	\$100 copay, deductible applies	\$100 copay, deductible applies	20% Coinsurance
<b>High Tech Imaging (e.g. MRI, CT and PET scans)</b>	No copay, deductible applies	No copay, deductible applies	20% Coinsurance
<b>PRESCRIPTION DRUGS</b>			
<b>Retail (Up to 30 day supply) Tier 1/Tier 2/Tier 3</b>	\$20/\$30/\$50 Deductible does not apply	\$20/\$30/\$50 Deductible does not apply	No Coverage
<b>Mail Order Maintenance Drugs (Up to a 90 day supply) Tier 1/Tier 2/Tier 3</b>	\$40/\$60/\$100 Deductible does not apply	\$40/\$60/\$100 Deductible does not apply	No Coverage
<b>Eye Exam (one per year)</b>	\$25 copay Deductible does not apply	\$25 copay Deductible does not apply	20% Coinsurance
<b>Chiropractic Care</b>	No copay, deductible applies limited to 12 visits per plan year	No copay Deductible applies	20% Coinsurance

This document is meant to assist you in reviewing plan comparability. Please review each plan's Summary of Benefits Coverage (SBC) and other plan documents as they supersede this document and will provide you with greater detail.