City of Newton Benefit Comparison Chart
Non Union and AFSCME 3092 and 3092B Employees
July 1, 2023 - June 30, 2024 Plan Year

	Blue Cross Blue Shield Network Blue New England (HMO)	**Blue Cross Blue Shield Blue Care Elect (PPO)**	
Website	www.bluecrossma.org		
Member Service Number	**1-800-782-3675**		
Out of Pocket Maximum Individual/Family	$1,000 individual/$2,500 family per plan year	$1,000 individual/$2,500 family per plan year	
Fiscal Year Deductible Individual/Family	$250 individual/ $500 family per plan year	$250 individual/ $500 family per plan year	
		In-Network	**Out-of-Network**
Primary Care Provider Office Visit	$20 copay Deductible does not apply	$20 copay Deductible does not apply	20% Coinsurance
Preventative Services	No copay Deductible does not apply	No copay Deductible does not apply	20% Coinsurance
Specialist Physician Office	$35 copay Deductible does not apply	$35 copay Deductible does not apply	20% Coinsurance
Retail Clinic/Limited Service Clinic	$5 copay Deductible does not apply	$5 copay Deductible does not apply	20% Coinsurance
Urgent Care Center	$10 copay Deductible does not apply	$10 copay Deductible does not apply	20% Coinsurance
Outpatient Behavioral Health & Substance Use Disorder Care	$20 copay Deductible does not apply	$20 copay Deductible does not apply	20% Coinsurance
Emergency Room Care	$100 copay Deductible does not apply	$100 copay Deductible does not apply	20% Coinsurance
Inpatient Hospital Care - Medical	No copay, deductible applies	No copay, deductible applies	20% Coinsurance
Maternity Benefits	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
Outpatient Surgery	$100 copay, deductible applies	$100 copay, deductible applies	20% Coinsurance
High Tech Imaging (e.g. MRI, CT and PET scans)	No copay, deductible applies	No copay, deductible applies	20% Coinsurance
PRESCRIPTION DRUGS			
Retail (Up to 30 day supply) Tier 1/Tier 2/Tier 3	$10/$25/$45 Deductible does not apply	$10/$25/$45 Deductible does not apply	No Coverage
Mail Order Maintenance Drugs (Up to a 90 day supply) Tier 1/Tier 2/Tier 3	$20/$50/$90 Deductible does not apply	$20/$50/$90 Deductible does not apply	No Coverage
Eye Exam (one per year)	$20 copay Deductible does not apply	$20 copay Deductible does not apply	20% Coinsurance
Chiropractic Care	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.