

Health Plan Comparison Chart

	PPO Plus Plan		PPO Plan		PPO HDHP Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductibles & Maximum Out-of-Pocket Expenses						
Annual Deductible	\$250 individual/ \$500 two-person or family	\$500 individual/ \$1,000 two-person or family	\$1,000 individual/ \$2,000 two-person or family	\$2,000 individual/ \$4,000 two-person or family	\$2,500 individual/ \$5,000 two-person or family	
University Contribution to Health Savings Account (HSA)	Not allowed, but employee can use FSA		Not allowed, but employee can use FSA		\$500 individual/ \$1,000 two-person or family	
Out-of-Pocket Maximum (includes deductible)	\$2,500 individual/ \$5,000 two-person or family		\$3,500 individual/ \$7,500 two-person or family		\$3,500 individual/ \$7,500 two-person or family	
Lifetime Maximum Benefits	Unlimited		Unlimited		Unlimited	
For the following covered services, YOU PAY						
Preventive Care	\$0 copay	Deductible then 20%	\$0 copay	Deductible then 20%	\$0 visit charge	Deductible then 40%
Office Visits and Outpatient Therapy (Occupational, Speech, Physical and Chiropractic)	\$15 copay	Deductible then 20%	\$35 copay	Deductible then 20%	Deductible then 20%	Deductible then 40%
Well Connection Telemedicine	\$15 copay		\$15 copay		Deductible then 20%	
Inpatient Hospital Using Blue Distinction Centers of Excellence	\$0 copay/ \$0 deductible	N/A	\$0 copay/ \$0 deductible	N/A	Deductible only, no coinsurance	N/A
Conception and Fertility Services	Call Progyny for personalized care	Not covered	Call Progyny for personalized care	Not covered	Call Progyny for personalized care	Not covered
Maternity Prenatal and Postnatal Visits	\$15 copay	Deductible then 20%	\$35 copay	Deductible then 20%	Deductible then 20%	Deductible then 40%
Lab & X-ray	\$0 copay	Deductible then 20%	Deductible then covered at 100%	Deductible then 20%	Deductible then 20%	Deductible then 40%
High-Cost Imaging (CT/PET scans, MRI)	Deductible then \$50 copay	Deductible then 20%	Deductible then \$50 copay	Deductible then 20%	Deductible then 20%	Deductible then 40%
Urgent Care Centers and Minute Clinics	\$15 copay	Deductible then 20%	\$35 copay	Deductible then 20%	Deductible then 20%	Deductible then 40%
Emergency Room	\$150 copay		\$200 copay		Deductible then 20%	
Inpatient Hospital	Deductible then \$250 copay per admission	Deductible then 20%	Deductible then no copay	Deductible then 20%	Deductible then 20%	Deductible then 40%
Outpatient Surgery	Deductible then \$150 copay per event	Deductible then 20%	Deductible then no copay	Deductible then 20%	Deductible then 20%	Deductible then 40%
Mental/Behavioral Health Inpatient Hospital	Deductible then \$250 copay per admission	Deductible then 20%	Deductible then no copay	Deductible then 20%	Deductible then 20%	Deductible then 40%
Mental/Behavioral Health Outpatient Services	\$15 copay	Deductible then 20%	\$35 copay	Deductible then 20%	Deductible then 20%	Deductible then 40%
Prescription Medication Tier Cost for 30-day Rx Scripts	Tier 1: \$10 copay Tier 2: \$25 copay Tier 3: \$50 copay	Not covered	Tier 1: \$10 copay Tier 2: \$25 copay Tier 3: \$50 copay	Not covered	Deductible then Tier 1: 0% Tier 2: 20% Tier 3: 20% PillarRX not available	Not covered
For ongoing RX prescriptions, all plans use Maintenance Choice (CVS retail or CVS Caremark Mail Service Pharmacy)	Certain specialty drugs require enrollment in PillarRX		Certain specialty drugs require enrollment in PillarRX			
Rx Enhancements	Value Rx Rider				ACA Preventive Care Rider	

If you enroll in a Tufts University Blue Cross Blue Shield health plan, you may also be eligible for a Fitness Reimbursement and/or Weight Loss Reimbursement: \$150 per member/\$300 per family per year. Visit access.tufts.edu/fitness-and-weight-loss-reimbursements for more information.

If you would like to compare plan costs, please visit the BCBS Coverage Advisor tool at bit.ly/3qN8Unt.