

FY26 Medical Plan Comparison.xlsx

PLAN YEAR 07/01/2025-06/30/2026	ANTHEM HMO 1500/3000	ANTHEM POS	ANTHEM HDHP With HSA* & Without HSA
Employee Contributions	See your specific employee group benefit guide	See your specific employee group benefit guide	See your specific employee group benefit guide
New England Network for All Plans: NH, VT, MA, ME, CT and RI (must use Anthem providers for in-network services)			
Deductible Preventive Care Services are covered at 100% for all plans when using in-network providers. <i>View guidelines for preventive care services at: www.Healthcare.gov search for "preventive care list"</i>	In-Network Deductible \$1500 deductible per person \$3000 per family each plan year Out-of-Network Deductible: No Services out-of-network Maximum out-of-pocket (OOP): \$6,450/ Single membership \$12,900/ Family membership <u>In-network</u> deductible ONLY applies to inpatient care and day surgery in hospital outpatient department or ambulatory surgical center.	In-Network Deductible \$250 deductible per person \$500 per family each plan year Out-of-Network Deductible: \$250 deductible per person \$750 per family each plan year (applies to all services) (then 20% coinsurance until OOP max) Maximum out-of-pocket (OOP): \$6,450/ Single membership \$12,900/ Family membership <u>In-network</u> deductible ONLY applies to inpatient care and day surgery in hospital outpatient department or ambulatory surgical center.	In-Network Deductible \$2,000/ Single membership** \$4,000/ Family membership** Out-of-Network: Maximum out-of-pocket (OOP): \$4,000/ Single membership \$8,000/ Family membership (30% coinsurance until OOP max) *City Contributes to HSA \$1,500/Single \$3,000/2P or Family **APPLIES to all services with the exception of in-network preventive care services.
Office Visits (PCP/Specialist)	\$25 Copay	In-network: \$20 Copay <u>Out-of-network</u> : subject to deductible, then covered at 80%	Subject to deductible, then covered at 100%
Telemedicine	Live Health Online \$25 per visit	Live Health Online \$20 per visit	Live Health Online \$49 per visit Covered at 100% if deductible is met
Routine Vision Exam One exam every 2 years	100% covered	<u>In-network</u> : 100% covered. <u>Out-of-network</u> : subject to deductible, then covered at 80%	<u>In-network</u> : 100% covered <u>Out-of-network</u> : subject to deductible, then covered at 100%
Chiropractic Visits Unlimited	\$25 Copay	<u>In-network</u> : \$20 Copay <u>Out-of-network</u> : subject to deductible, then covered at 80%	Subject to deductible, then covered at 100%
Durable Medical and Prosthetic Equipment Unlimited	100% covered	<u>In-network</u> : 100% covered. <u>Out-of-network</u> : subject to deductible, then covered at 80%	Subject to deductible, then covered at 100%
Outpatient Surgery Performed in a hospital or surgical center	Subject to deductible, then covered at 100%	<u>In-network</u> : deductible applies <u>Out-of-network</u> : subject to deductible, then covered at 80%	Subject to deductible, then covered at 100%
Hospital Inpatient (including acute and psychiatric)	Subject to deductible, then covered at 100%	<u>In-network</u> : deductible applies <u>Out-of-network</u> : subject to deductible, then covered at 80%	Subject to deductible, then covered at 100%
Inpatient Rehabilitation Services Limited to 60 days per calendar Year	Subject to deductible, then covered at 100%	<u>In-network</u> : deductible applies <u>Out-of-network</u> : subject to deductible, then covered at 80%	Subject to deductible, then covered at 100%
Outpatient Rehabilitation Services (physical, occupational, speech) Limited to 60 visits per calendar Year	\$25 Copay	<u>In-network</u> : \$20 Copay <u>Out-of-network</u> : subject to deductible, then covered at 80%	Subject to deductible, then covered at 100%
Emergency Room	\$100 per Visit Waived if admitted	\$100 per Visit Waived if admitted	Subject to deductible, then covered at 100%
Urgent Care	\$25 Convenience/Urgent Care \$50 Hospital Urgent Care Clinic	\$20 Convenience/Urgent Care \$50 Hospital Urgent Care Clinic	Subject to deductible, then covered at 100%
Retail Pharmacy (up to a 30 day supply)	\$10 Tier 1 - Generic Drugs \$30 Tier 2 - Preferred \$50 Tier 3 - Non-Preferred / Specialty	\$5 Tier 1 - Generic Drugs \$15 Tier 2 - Preferred \$35 Tier 3 - Non-Preferred / Specialty	Subject to deductible, then covered at 100%
Mail Order Pharmacy (up to a 90 day supply)	\$20 Tier 1 - Generic Drugs \$60 Tier 2 - Preferred \$100 Tier 3- Non-Preferred / Specialty	\$5 Tier 1 - Generic Drugs \$30 Tier 2 - Preferred \$70 Tier 3- Non-Preferred / Specialty	Subject to deductible, then covered at 100%
Visit your City or NSD websites HR/benefits section for more detailed plan information in each of the Summary of Benefit Coverage (SBC) documents.			