2026 Health Plan Comparison Guide

w/Rate Sheet for School Active Employees

Please note: Health plan weekly rates are effective from **April 1st, 2026** until **March 31st, 2027**

Blue Choice

Individual

100% Monthly Cost $1,618.72

15% Weekly Rate	15% Semi-Monthly
$56.03	$121.40
18% Weekly Rate	18% Semi-Monthly
$67.24	$145.68
19% Weekly Rate	19% Semi-Monthly
$70.97	$153.78
20% Weekly Rate	20% Semi-Monthly
$74.71	$161.87
25% Weekly Rate	25% Semi-Monthly
$93.39	$202.34

Family

100% Monthly Cost $4,127.73

15% Weekly Rate	15% Semi-Monthly
$142.88	$309.58
18% Weekly Rate	18% Semi-Monthly
$171.46	$371.50
19% Weekly Rate	19% Semi-Monthly
$180.99	$392.13
20% Weekly Rate	20% Semi-Monthly
$190.51	$412.77
25% Weekly Rate	25% Semi-Monthly
$238.14	$515.97

PCP	Required
Referrals	Optional
Plan Type	POS
Coverage Area	New England (new)
Out of Network	Yes
Annual Deductible	PCP/Plan Approved $0 Self-Referred $250mbr/$500fam
Out of Pocket Max	$7,150 Individual / $14,300 Family

Website: www.bcbsma.com
Telephone: 1-800-782-3675

HMO Blue New England

Individual

100% Monthly Cost $1,212.32

15% Weekly Rate	15% Semi-Monthly
$41.96	$90.92
18% Weekly Rate	18% Semi-Monthly
$50.36	$109.11
19% Weekly Rate	19% Semi-Monthly
$53.16	$115.17
20% Weekly Rate	20% Semi-Monthly
$55.95	$121.23
25% Weekly Rate	25% Semi-Monthly
$69.94	$151.54

Family

100% Monthly Cost $3,104.05

15% Weekly Rate	15% Semi-Monthly
$107.45	$232.80
18% Weekly Rate	18% Semi-Monthly
$128.94	$279.36
19% Weekly Rate	19% Semi-Monthly
$136.10	$294.88
20% Weekly Rate	20% Semi-Monthly
$143.26	$310.41
25% Weekly Rate	25% Semi-Monthly
$179.08	$388.01

PCP	Required
Referrals	Required
Plan Type	HMO
Coverage Area	New England
Out of Network	No. Emergent Care Only
Annual Deductible	$0
Out of Pocket Max	$7,150 Individual / $14,300 Family

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Harvard Pilgrim

Individual

100% Monthly Cost $1,134.41

15% Weekly Rate	15% Semi-Monthly
$39.27	$85.08
18% Weekly Rate	18% Semi-Monthly
$47.12	$102.10
19% Weekly Rate	19% Semi-Monthly
$49.74	$107.77
20% Weekly Rate	20% Semi-Monthly
$52.36	$113.44
25% Weekly Rate	25% Semi-Monthly
$65.45	$141.80

Family

100% Monthly Cost $3,107.77

15% Weekly Rate	15% Semi-Monthly
$107.58	$233.08
18% Weekly Rate	18% Semi-Monthly
$129.09	$279.70
19% Weekly Rate	19% Semi-Monthly
$136.26	$295.24
20% Weekly Rate	20% Semi-Monthly
$143.44	$310.78
25% Weekly Rate	25% Semi-Monthly
$179.29	$388.47

PCP	Required
Referrals	Required
Plan Type	HMO
Coverage Area	New England - excluding CT
Out of Network	No. Emergent Care Only
Annual Deductible	$0
Out of Pocket Max	$2,000 Individual / $4,000 Family

Website: harvardpilgrim.org
Telephone: 1-888-333-4742

Covered Services

Blue Choice	HMO Blue New England	Harvard Pilgrim
Hospitalization, Sugrical/Specialty SVCS 100% Coverage	**Hospitalization, Sugrical/Specialty SVCS** 100% Coverage	**Hospitalization, Sugrical/Specialty SVCS** 100% Coverage
Annual Physical No co-pay	**Annual Physical** No co-pay	**Annual Physical** No co-pay
Office Visits/Specialist $25.00 co-pay	**Office Visits/Specialist** $25.00 co-pay	**Office Visits/Specialist** $25.00 co-pay
Chiropractor Visits PCP/Plan Approved (Not Covered)	**Chiropractor Visits** $25.00 co-pay, *up to 12 per year*	**Chiropractor Visits** $25.00 co-pay, up to 12 per year (new)
X-Rays & Lab Tests 100% Coverage	**X-Rays & Lab Tests** 100% Coverage	**X-Rays & Lab Tests** 100% Coverage
High-Tech Imaging Tests (MRIs, Scans) $25.00 co-pay	**High-Tech Imaging Tests (MRIs, Scans)** $25.00 co-pay	**High-Tech Imaging Tests (MRIs, Scans)** $25.00 co-pay
Accupunture Benefits $25.00 co-pay, *up to 12 per year*	**Accupunture Benefits** $25.00 co-pay, *up to 12 per year*	**Accupunture Benefits** $25.00 co-pay
Telehealth Benefits $0 for virtual care team primary care provider (new)	**Telehealth Benefits** $0 for virtual care team primary care provider (new)	**Telehealth Benefits** $25.00 co-pay, *$0 w/Doctors on Demand*
Pediatric Dental Benefits No charge for members with a cleft palate/cleft lip condition	**Pediatric Dental Benefits** Preventive care under age 12 100% Coverage	**Pediatric Dental Benefits** Preventative care up to age 13 100% Coverage
Hearing & Vision Benefits Routine Eye Exam every 24 months; Hearing Aids $2,000 per ear every 36 months	**Hearing & Vision Benefits** Routine Eye Exam every 24 months; Hearing Aids $2,000 per ear every 36 months	**Hearing & Vision Benefits** Routine Eye Exam every 12 months; Hearing Aids $2,000 per ear every 36 months
Physical, Speech & Occupational Therapy $25.00 co-pay, up to 60 visits per year for Occupational, Physical and Speech Therapy	**Physical, Speech & Occupational Therapy** $25.00 co-pay, up to 60 visits per year for Occupational, Physical and Speech Therapy	**Physical, Speech & Occupational Therapy** $25.00 co-pay, up to 60 visits per year for OT and PT, Speech Unlimited
Ambulance 100% Coverage	**Ambulance** 100% Coverage	**Ambulance** 100% Coverage
Emergency Room $100 co-pay	**Emergency Room** $100 co-pay	**Emergency Room** $100 co-pay
Durable Medical Equipment 80% Coverage	**Durable Medical Equipment** 80% Coverage	**Durable Medical Equipment** 100% Coverage
Direct Purchase (30-day supply) $10/$30/$50 co-pay generic, preferred or non-preferred brand	**Direct Purchase (30-day supply)** $10/$30/$50 co-pay generic, preferred or non-preferred brand	**Direct Purchase (30-day supply)** $10/$30/$50 co-pay generic, brand formulary or brand non-formulary
Mail Order (90-day supply) $10/$30/$50 co-pay generic, preferred or non-preferred brand	**Mail Order (90-day supply)** $10/$30/$50 co-pay generic, preferred or non-preferred brand	**Mail Order (90-day supply)** $20/$60/$150 co-pay generic, brand formulary or brand non-formulary
Fitness Club Benefits $300 per household toward health club membership or classes	**Fitness Club Benefits** $300 per household toward health club membership or classes	**Fitness Club Benefits** $300 per household toward health club, nutrition apps etc.
Weight Watchers Benefits $300 weight watchers benefit	**Weight Watchers Benefits** $300 weight watchers benefit	**Weight Watchers Benefits** $300 weight watchers benefit
Mind & Body Benefit $300 per family per calendar year towards qualified services	**Mind & Body Benefit** $300 per family per calendar year towards qualified services	**Mind & Body Benefit** No Coverage

All plans offer **additional** wellness discounts, disease management programs, health articles, tools, resources etc. Plan differences have been highlighted.