Harvard Pilgrim Health Care of New England

City of Concord

2025 - 2026

	Plan Choice 1 **Best Buy $500 Low $25**	Plan Choice 2 **HMO Elevate Health Option**		Plan Choice 3 **Best Buy HSA**
		Tier 1	**Tier 2**	
Office Copay	$25 copay / visit *(No copay for preventive visits)*	$25 copay / visit *(No copay for preventive visits)*	Deductible then 20% coinsurance *(No copay for preventive visits)*	Deductible then CIF / visit *(No charge for preventive visits)*
Individual/Family Deductible	$500/$1500 per plan year	$500/$1000 per plan year	$1500/$3000 per plan year	$2000/$4000 per plan year
Surgery	Covered in full after deductible	Deductible then $150 copay	Deductible then 20% coinsurance	Covered in full after deductible
Inpatient Hospital Stay	Covered in full after deductible	Covered in full after deductible	Deductible then 20% coinsurance	Covered in full after deductible
ER Copay	$100 / visit	Deductible then $100 copay		Covered in full after deductible
MRI / CT Scan	Covered in full after deductible	Covered in full after deductible	Deductible then 20% coinsurance	Covered in full after deductible
Ambulance	Covered in full after deductible	Covered in full after deductible	Deductible then 20% coinsurance	Covered in full after deductible
Outpatient Mental Health	$25 copay / visit for individual $5 copay / visit group therapy	$25 copay / visit for individual $5 copay / visit group therapy	Deductible then 20% coinsurance	Covered in ful after deductible
Inpatient Mental health	Covered in full	Covered in full	Deductible then 20% coinsurance	Covered in full after deductible
Outpatient Substance / Alcohol Rehabilitation	$25 copay / visit for individual $5 copay / visit group therapy	$25 copay / visit for individual $10 copay / visit group therapy		Covered in full after deductible
Inpatient Substance / Alcohol Rehabilitation	Covered in full	Covered in full		Covered in full after deductible
PT / OT	$25 copay per visit (unlimited)	$25 copay per visit (unlimited)	Deductible then 20% coinsurance	Covered in full after deductible (60 visits combined PT/ST/OT)
ST (Speech Therapy)	$25 visit per visit (unlimited)	$25 visit per visit (unlimited)	Deductible then 20% coinsurance	Covered in full after deductible (60 visits combined PT/ST/OT)
Skilled Nursing Facility / Inpatient Rehabilitation	Combined up to 100 days /py Covered in full after deductible	Combined up to 100 days /py Covered in full after deductible	Deductible then 20% coinsurance	Combined up to 100 days /py Covered in full after deductible
Chiropractic Care (limit combined in/out)	$25 copay per visit (unlimited)	$25 copay per visit (unlimited)	Deductible then 20% coinsurance	Covered in full after deductible Up to 12 visits/py
Labwork	Covered in full	Covered in full	Deductible then 20% coinsurance	Covered in full after deductible
Routine Eye Exams	1 visit per py $25 copay / visit	$25 copay / visit	Deductible then 20% coinsurance	1 visit per py No charge
DME (Durable Medical Equipment)	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Deductible then 20% coinsurance	Covered in full after deductible
Out of Pocket Maximum	$2,000 individual / $4,000 Family	$2,000 individual / $4,000 Family		$2,000 individual plans only / $4,000 2P or Family plans
Lifetime Maximum	Unlimited	Unlimited		Unlimited
Please note that on the High Deductible plan, Harvard considers a 2 Person plan "Family"				
Prescription Drug Benefits				
Retail (up to 30 day supply)	$5/$25/$40/30% ($300 max per scrip for Tier 4)	$5/$25/$40/30% ($300 max per scrip)		Covered in full after deductible *(preventive RX not subject to deductible and covered in full)*
Mail Order (up to 90 day supply)	$5/$25/$40/30% ($300 max per scrip for Tier 4)	$5/$25/$40/30% ($300 max per scrip)		Covered in full after deductible
Out of Pocket Maximum	$4,000 individual / $8,000 Family	$4,000 individual / $8,000 Family		N/A