

# 2026 Health Plan Comparison Guide

w/Rate Sheet for Non-Medicare Eligible Retirees



## 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
10% Monthly	\$161.87
15% Monthly	\$242.81

#### Family

100% Monthly Cost	\$4,127.73
10% Monthly	\$412.77
15% Monthly	\$619.16

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](http://www.bcbsma.com)  
Telephone: 1-800-782-3675

### HMO Blue New England

#### Individual

100% Monthly Cost	\$1,212.32
10% Monthly	\$121.23
15% Monthly	\$181.85

#### Family

100% Monthly Cost	\$3,104.05
10% Monthly	\$310.41
15% Monthly	\$465.61

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
10% Monthly	\$113.44
15% Monthly	\$170.16

#### Family

100% Monthly Cost	\$3,107.77
10% Monthly	\$310.78
15% Monthly	\$466.17

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

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### Advantage Blue

#### Individual

100% Monthly Cost	\$2,125.96
10% Monthly	\$212.60
15% Monthly	\$318.89

#### Family

100% Monthly Cost	\$5,315.00
10% Monthly	\$531.50
15% Monthly	\$797.25

PCP	Not Required
Referrals	Optional
Plan Type	EPO
Coverage Area	BCBS Nationwide Network
Out of Network	No - Emergent Care Only
Annual Deductible	\$0
Out of Pocket Max	\$7,150 Individual / \$14,300 Family

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# Covered Services

Blue Choice	HMO Blue New England	Harvard Pilgrim	Advantage Blue
 <b>Hospitalization, Sugrical/Specialty SVCS</b> 100% Coverage	 <b>Hospitalization, Sugrical/Specialty SVCS</b> 100% Coverage	 <b>Hospitalization, Sugrical/Specialty SVCS</b> 100% Coverage	 <b>Hospitalization, Sugrical/Specialty SVCS</b> 100% Coverage
 <b>Annual Physical</b> No co-pay	 <b>Annual Physical</b> No co-pay	 <b>Annual Physical</b> No co-pay	 <b>Annual Physical</b> No co-pay
 <b>Office Visits/Specialist</b> \$25.00 co-pay	 <b>Office Visits/Specialist</b> \$25.00 co-pay	 <b>Office Visits/Specialist</b> \$25.00 co-pay	 <b>Office Visits/Specialist</b> \$25.00 co-pay
 <b>Chiropractor Visits</b> PCP/Plan Approved (Not Covered)	 <b>Chiropractor Visits</b> \$25.00 co-pay, <i>up to 12 visits per year</i>	 <b>Chiropractor Visits</b> \$25.00 co-pay, <i>up to 12 visits per year (new)</i>	 <b>Chiropractor Visits</b> \$25.00 co-pay
 <b>X-Rays &amp; Lab Tests</b> 100% Coverage	 <b>X-Rays &amp; Lab Tests</b> 100% Coverage	 <b>X-Rays &amp; Lab Tests</b> 100% Coverage	 <b>X-Rays &amp; Lab Tests</b> 100% Coverage
 <b>High-Tech Imaging Tests (MRIs, Scans)</b> \$25.00 co-pay	 <b>High-Tech Imaging Tests (MRIs, Scans)</b> \$25.00 co-pay	 <b>High-Tech Imaging Tests (MRIs, Scans)</b> \$25.00 co-pay	 <b>High-Tech Imaging Tests (MRIs, Scans)</b> \$25.00 co-pay
 <b>Accupuncture Benefits</b> \$25.00 co-pay, <i>up to 12 per year</i>	 <b>Accupuncture Benefits</b> \$25.00 co-pay, <i>up to 12 per year</i>	 <b>Accupuncture Benefits</b> \$25.00 co-pay	 <b>Accupuncture Benefits</b> \$25.00 co-pay, <i>up to 12 per year</i>
 <b>Telehealth Benefits</b> \$0 for virtual care team primary care provider (new)	 <b>Telehealth Benefits</b> \$0 for virtual care team primary care provider (new)	 <b>Telehealth Benefits</b> \$25 co-pay \$0 w/Doctors on Demand	 <b>Telehealth Benefits</b> \$0 for virtual care team primary care provider (new)
 <b>Pediatric Dental Benefits</b> No charge for members with a cleft palate/cleft lip condition	 <b>Pediatric Dental Benefits</b> \$0 Preventive dental care for children under age 12 (one visit each 6 months)	 <b>Pediatric Dental Benefits</b> \$0 Preventative Care for children up to age 13	 <b>Pediatric Dental Benefits</b> No charge for members with a cleft palate/cleft lip condition
 <b>Hearing &amp; Vision Benefits</b> Routine Eye Exam every 24 months; Hearing Aids \$2,000 per ear every 36 months	 <b>Hearing &amp; Vision Benefits</b> Routine Eye Exam every 24 months; Hearing Aids \$2,000 per ear every 36 months	 <b>Hearing &amp; Vision Benefits</b> Routine Eye Exam every 12 months; Hearing Aids \$2,000 per ear every 36 months	 <b>Hearing &amp; Vision Benefits</b> Routine Eye Exam every 24 months; Hearing Aids \$2,000 per ear every 36 months
 <b>Physical, Speech &amp; Occupational Therapy</b> \$25.00 co-pay, up to 60 visits per year for Occupational, Physical and Speech Therapy	 <b>Physical, Speech &amp; Occupational Therapy</b> \$25.00 co-pay, up to 60 visits per year for Occupational, Physical and Speech Therapy	 <b>Physical, Speech &amp; Occupational Therapy</b> \$25.00 co-pay, up to 60 visits per year for OT & PT, Speech Unlimited	 <b>Physical, Speech &amp; Occupational Therapy</b> \$25.00 co-pay, up to 60 visits per year for Occupational, Physical and Speech Therapy
 <b>Ambulance</b> 100% Coverage	 <b>Ambulance</b> 100% Coverage	 <b>Ambulance</b> 100% Coverage	 <b>Ambulance</b> 100% Coverage
 <b>Emergency Room</b> \$100 co-pay	 <b>Emergency Room</b> \$100 co-pay	 <b>Emergency Room</b> \$100 co-pay	 <b>Emergency Room</b> \$100 co-pay
 <b>Durable Medical Equipment</b> 80% Coverage	 <b>Durable Medical Equipment</b> 80% Coverage	 <b>Durable Medical Equipment</b> 100% Coverage	 <b>Durable Medical Equipment</b> 80% Coverage w/ no limit for prosthetics
 <b>Direct Purchase (30-day supply)</b> \$10/\$30/\$50 co-pay generic, preferred or non-preferred brand	 <b>Direct Purchase (30-day supply)</b> \$10/\$30/\$50 co-pay generic, preferred or non-preferred brand	 <b>Direct Purchase (30-day supply)</b> \$10/\$30/\$50 co-pay generic/ brand formulary/ brand non-formulary	 <b>Direct Purchase (30-day supply)</b> \$10/\$30/\$50 co-pay generic, preferred or non-preferred brand
 <b>Mail Order (90-day supply)</b> \$10/\$30/\$50 co-pay generic, preferred or non-preferred brand	 <b>Mail Order (90-day supply)</b> \$10/\$30/\$50 co-pay generic, preferred or non-preferred brand	 <b>Mail Order (90-day supply)</b> \$20/\$60/\$150 co-pay generic/ brand formulary/ brand non-formulary	 <b>Mail Order (90-day supply)</b> \$10/\$30/\$50 co-pay generic, preferred or non-preferred brand
 <b>Fitness Club Benefits</b> \$300 per household toward health club membership or classes	 <b>Fitness Club Benefits</b> \$300 per household toward health club membership or classes	 <b>Fitness Club Benefits</b> \$300 per household toward health club, nutrition apps etc.	 <b>Fitness Club Benefits</b> \$300 per household toward health club membership or classes
 <b>Weight Watchers Benefits</b> \$300 weight watchers benefit	 <b>Weight Watchers Benefits</b> \$300 weight watchers benefit	 <b>Weight Watchers Benefits</b> \$300 Weight Watchers benefit	 <b>Weight Watchers Benefits</b> \$300 weight watchers benefit
 <b>Mind &amp; Body Benefit</b> \$300 per family per calendar year towards qualified services	 <b>Mind &amp; Body Benefit</b> \$300 per family per calendar year towards qualified services	 <b>Mind &amp; Body Benefit</b> No Coverage	 <b>Mind &amp; Body Benefit</b> \$300 per family per calendar year towards qualified services