

2026

Health Plan Comparison Guide

w/Rate Sheet for City 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 \$56.03
18% Weekly Rate \$67.24

20% Weekly Rate \$74.71
25% Weekly Rate \$93.39

Family **100% Monthly Cost**
\$4,127.73

15% Weekly Rate \$142.88
18% Weekly Rate \$171.46

20% Weekly Rate \$190.51
25% Weekly Rate \$238.14

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 \$41.96
18% Weekly Rate \$50.36

20% Weekly Rate \$55.95
25% Weekly Rate \$69.94

Family **100% Monthly Cost**
\$3,104.05

15% Weekly Rate \$107.45
18% Weekly Rate \$128.94

20% Weekly Rate \$143.26
25% Weekly Rate \$179.08

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

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

Harvard Pilgrim

Individual **100% Monthly Cost**
\$1,134.41

15% Weekly Rate \$39.27
18% Weekly Rate \$47.12

20% Weekly Rate \$52.36
25% Weekly Rate \$65.45

Family **100% Monthly Cost**
\$3,107.77

15% Weekly Rate \$107.58
18% Weekly Rate \$129.09

20% Weekly Rate \$143.44
25% Weekly Rate \$179.29

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

 **Annual Physical**
No co-pay

 **Office Visits/Specialist**
\$25.00 co-pay

 **Chiropractor Visits**
PCP/Plan Approved (Not Covered)

 **X-Rays & Lab Tests**
100% Coverage

 **High-Tech Imaging Tests (MRIs, Scans)**
\$25.00 co-pay

 **Accupuncture Benefits**
\$25.00 co-pay, up to 12 per year

 **Telehealth Benefits**
\$0 for virtual care team primary care provider (new)

 **Pediatric Dental Benefits**
No charge for members with a cleft palate/cleft lip condition

 **Hearing & Vision Benefits**
Routine Eye Exam every 24 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

 **Ambulance**
100% Coverage

 **Emergency Room**
\$100 co-pay

 **Durable Medical Equipment**
80% Coverage

 **Direct Purchase (30-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

 **Fitness Club Benefits**
\$300 per household toward health club membership or classes

 **Weight Watchers Benefits**
\$300 weight watchers benefit

 **Mind & Body Benefit**
\$300 per family per calendar year towards qualified services

 **Hospitalization, Sugrical/Specialty SVCS**
100% Coverage

 **Annual Physical**
No co-pay

 **Office Visits/Specialist**
\$25.00 co-pay

 **Chiropractor Visits**
\$25.00 co-pay, up to 12 per year

 **X-Rays & Lab Tests**
100% Coverage

 **High-Tech Imaging Tests (MRIs, Scans)**
\$25.00 co-pay

 **Accupuncture Benefits**
\$25.00 co-pay, up to 12 per year

 **Telehealth Benefits**
\$0 for virtual care team primary care provider (new)

 **Pediatric Dental Benefits**
Preventive care under age 12
100% Coverage

 **Hearing & Vision Benefits**
Routine Eye Exam every 24 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

 **Ambulance**
100% Coverage

 **Emergency Room**
\$100 co-pay

 **Durable Medical Equipment**
80% Coverage

 **Direct Purchase (30-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

 **Fitness Club Benefits**
\$300 per household toward health club membership or classes

 **Weight Watchers Benefits**
\$300 weight watchers benefit

 **Mind & Body Benefit**
\$300 per family per calendar year towards qualified services

 **Hospitalization, Sugrical/Specialty SVCS**
100% Coverage

 **Annual Physical**
No co-pay

 **Office Visits/Specialist**
\$25.00 co-pay

 **Chiropractor Visits**
\$25.00 co-pay, up to 12 per year (new)

 **X-Rays & Lab Tests**
100% Coverage

 **High-Tech Imaging Tests (MRIs, Scans)**
\$25.00 co-pay

 **Accupuncture Benefits**
\$25.00 co-pay

 **Telehealth Benefits**
\$25.00 co-pay, \$0 w/Doctors on Demand

 **Pediatric Dental Benefits**
Preventative care up to age 13
100% Coverage

 **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 OT and PT, Speech Unlimited

 **Ambulance**
100% Coverage

 **Emergency Room**
\$100 co-pay

 **Durable Medical Equipment**
100% Coverage

 **Direct Purchase (30-day supply)**
\$10/\$30/\$50 co-pay generic, brand formulary or brand non-formulary

 **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, nutrition apps etc.

 **Weight Watchers Benefits**
\$300 weight watchers benefit

 **Mind & Body Benefit**
No Coverage

All plans offer **additional** wellness discounts, disease management programs, health articles, tools, resources etc.