Harvard Pilgrim Health Care

a Point32Health company

BENTLEY UNIVERSITY

Bentley University – 2026 Medical Plans Comparison Summary

Plan Feature	Best Buy HMO High-quality coverage at a more affordable premium than a traditional HMO. This product includes an annual deductible and 10% coinsurance on some services.	HMO A traditional HMO plan. Most services are covered in full after a deductible and copayment.	HDHP with HSA Quality coverage at the lowest premium compared to other plans. All non-preventive services are subject to the deductible. If you are eligible, Bentley will contribute to your HSA to help offset out-of-pocket costs, and you can also contribute. Coverage available in-network and out-of-network. No PCP referrals required.	
	In-Network	In-Network	In-Network	Out-of-Network
Annual Deductible	$1,250 per member $2,500 per family	$500 per member $1,000 per family	$2,250 per member[3] $4,500 per family[3]	$4,500 per member[3] $9,000 per family[3]
Out-of-Pocket Maximum	$2,500 per member[1] $5,000 per family[1]	$2,500 per member[2] $5,000 per family[2]	$4,500 per member[4] $9,000 per family[4]	$6,750 per member[4] $13,500 per family[4]
Preventive Care				
Annual Routine Physical Exam	Covered in full	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance
Annual Routine Eye Exam	$25 per visit	$25 per visit	$25 copayment	Subject to deductible, then 30% coinsurance
Well-Child Exam	Covered in full	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance
Outpatient Medical Care				
Non-Routine Office Visits with Primary Care or Specialist	$25 per visit with PCP $35 per visit with specialist	$25 per visit with PCP $35 per visit with specialist	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Diagnostic Imaging (e.g. X-rays, Ultrasounds) & Lab Tests	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
High-Tech Imaging (e.g. MRI, CT, PET and Nuclear Cardiology)	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Physical/Occupational/Speech Therapy	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Inpatient Hospital Care				
Hospitalization	Subject to deductible, then 10% coinsurance	Subject to deductible, then $250 per admission copayment	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Day Surgery	Subject to deductible, then 10% coinsurance	Subject to deductible, then $150 copayment	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Maternity Care				
Outpatient Care	Covered in full	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance
Inpatient Care	Subject to deductible, then 10% coinsurance	Subject to deductible, then $250 per admission copayment	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Routine Newborn Inpatient Care	Covered in full	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance

Emergency Care				
Office Visit	$25 per visit with Primary Care $35 per visit with Specialist	$25 per visit with Primary Care $35 per visit with Specialist	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Urgent Care	$35 per visit	$35 per visit	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Emergency Room	$200 per visit (Copayment waived if admitted)	$200 per visit (Copayment waived if admitted)	Subject to deductible, then 15% coinsurance	Subject to deductible, then 15% coinsurance
Chiropractic Care				
Spinal Manipulation	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Mental Health				
Outpatient Care	$25 per visit	$25 per visit	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Inpatient Care	Subject to deductible, then 10% coinsurance	Subject to deductible, then $250 per admission copayment	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Substance Abuse				
Outpatient Care	$25 per visit	$25 per visit	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Inpatient Care	Subject to deductible, then 10% coinsurance	Subject to deductible, then $250 per admission copayment	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Durable Medical Equipment				
	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 15% coinsurance	Subject to deductible, then 30% coinsurance
Prescription Drugs				
	Retail (30 day supply)		**Deductible applies, then copays:**	
Tier 1 copayment	$15	$15	$15	
Tier 2 copayment	$30	$30	$30	
Tier 3 copayment	$50	$50	$50	
	Mail-Order (90 day supply)		**Deductible applies, then copays:**	
Tier 1 copayment	$30	$30	$30	
Tier 2 copayment	$60	$60	$60	
Tier 3 copayment	$100	$100	$100	

The out-of-pocket maximum is the most an individual member or family unit would pay for services in a calendar year.

1 Includes medical copayments, prescription copayments, deductible and coinsurance.

2 Includes medical copayments, prescription copayments, and deductible.

3 Any eligible medical expenses you incur toward the in-network deductible in a calendar year applies to both the in-network and the out-of-network deductibles. Likewise, any eligible expenses you incur toward the out-of-network deductible in a calendar year applies to both the in-network and the out-of-network deductibles.

4 Any eligible medical expenses you incur toward the in-network out-of-pocket maximums in a calendar year applies to both the in-network and the out-of-network out-of-pocket maximums. Likewise, any eligible expenses you incur toward the out-of-network out-of-pocket maximum in a calendar year applies to both the in-network and the out-of-network out-of-pocket maximums.

This chart includes only a brief summary of plan provisions. See member documents for more detailed information. In the event of a discrepancy, the official plan documents will govern.

A Summary of Benefits and Coverage (SBC) for each plan is available from your employer at bentley.edu/offices/human-resources/benefits as well as other member documents.

You may request paper copies from Bentley Human Resources at 781-891-2817. If you enroll in a plan, you are responsible for providing a copy of the SBC notice to your covered dependents.