

# Bentley University – 2025 Medical Plans Comparison Summary

Plan Feature	Best Buy HMO		HMO		HDHP with HSA	
	High-quality coverage at a more affordable premium than a traditional HMO. This product includes an annual deductible and 10% coinsurance on some services.		A traditional HMO plan. Most services are covered in full after a deductible and copayment.		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	In-Network	Out-of-Network	Out-of-Network
<b>Annual Deductible</b>	\$1,000 per member \$2,000 per family	\$250 per member \$500 per family	\$250 per member \$500 per family	\$2,000 per member <sup>3</sup> \$4,000 per family <sup>3</sup>	\$4,000 per member <sup>3</sup> \$8,000 per family <sup>3</sup>	\$4,000 per member <sup>3</sup> \$8,000 per family <sup>3</sup>
<b>Out-of-Pocket Maximum</b>	\$2,000 per member <sup>1</sup> \$4,000 per family <sup>1</sup>	\$2,000 per member <sup>2</sup> \$4,000 per family <sup>2</sup>	\$2,000 per member <sup>2</sup> \$4,000 per family <sup>2</sup>	\$4,000 per member <sup>4</sup> \$8,000 per family <sup>4</sup>	\$6,000 per member <sup>4</sup> \$12,000 per family <sup>4</sup>	\$6,000 per member <sup>4</sup> \$12,000 per family <sup>4</sup>
<b>Preventive Care</b>						
<b>Annual Routine Physical Exam</b>	Covered in full	Covered in full	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance	Subject to deductible, then 20% coinsurance
<b>Annual Routine Eye Exam</b>	\$25 per visit	\$25 per visit	\$25 per visit	\$25 copayment	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance
<b>Well-Child Exam</b>	Covered in full	Covered in full	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance	Subject to deductible, then 20% coinsurance
<b>Outpatient Medical Care</b>						
<b>Non-Routine Office Visits with Primary Care or Specialist</b>	\$25 per visit	\$25 per visit	\$25 per visit	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance
<b>Diagnostic Imaging (e.g. X-rays, Ultrasounds) &amp; Lab Tests</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance
<b>High-Tech Imaging (e.g. MRI, CT, PET and Nuclear Cardiology)</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance
<b>Physical/Occupational/Speech Therapy</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then covered in full	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance
<b>Inpatient Hospital Care</b>						
<b>Hospitalization</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then \$250 per admission copayment	Subject to deductible, then \$250 per admission copayment	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance
<b>Day Surgery</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then \$150 copayment	Subject to deductible, then \$150 copayment	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance
<b>Maternity Care</b>						
<b>Outpatient Care</b>	Covered in full	Covered in full	Covered in full	Subject to deductible, then 10% coinsurance	Subject to deductible, then 20% coinsurance	Subject to deductible, then 20% coinsurance
<b>Inpatient Care</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then \$250 per admission copayment	Subject to deductible, then \$250 per admission copayment	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance
<b>Routine Newborn Inpatient Care</b>	Covered in full	Covered in full	Covered in full	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 30% coinsurance

Emergency Care				
<b>Office Visit</b>	\$25 per visit with Primary Care \$25 per visit with Specialist	\$25 per visit with Primary Care \$25 per visit with Specialist	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance
<b>Urgent Care</b>	\$25 per visit	\$25 per visit	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance
<b>Emergency Room</b>	\$150 per visit (Copayment waived if admitted)	\$150 per visit (Copayment waived if admitted)	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance
Chiropractic Care				
<b>Spinal Manipulation</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance
Mental Health				
<b>Outpatient Care</b>	\$25 per visit	\$25 per visit	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance
<b>Inpatient Care</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then \$250 per admission copayment	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance
Substance Abuse				
<b>Outpatient Care</b>	\$25 per visit	\$25 per visit	Subject to deductible, then 10% coinsurance	Subject to deductible, then 30% coinsurance
<b>Inpatient Care</b>	Subject to deductible, then 10% coinsurance	Subject to deductible, then \$250 per admission copayment	Subject to deductible, then 10% 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 10% coinsurance	Subject to deductible, then 30% coinsurance
Prescription Drugs				
	Retail (30 day supply)		Deductible applies, then copays:	
<b>Tier 1 copayment</b>	\$15	\$15	\$15	
<b>Tier 2 copayment</b>	\$30	\$30	\$30	
<b>Tier 3 copayment</b>	\$50	\$50	\$50	
	Mail-Order (90 day supply)		Deductible applies, then copays:	
<b>Tier 1 copayment</b>	\$30	\$30	\$30	
<b>Tier 2 copayment</b>	\$60	\$60	\$60	
<b>Tier 3 copayment</b>	\$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](http://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.