Brandeis University

2026 Harvard Pilgrim Health Plan Services Comparison Chart

covered Services	Best Buy HSA HMO	Best Buy HMO	HMO	PPO In-Network	PPO Out-of-Network
Provider Network	HPHC	HPHC	HPHC	HPHC/ UnitedHealthCare	none
Out of Pocket Maximum	$4,000 for single $8,000 for family	$5,000 for single $10,000 for family	$2,500 for single $5,000 for family	$2,500 for single $5,000 for family	$2,500 for single $5,000 for family
Annual Deductible	$2,000 for single $4,000 for family	$1,000 for Single $2,000 for Family	N/A	N/A	$500 for Single $1,000 for Family
Urgent Care	$30 copay after deductible is met	$25 per visit	$25 per visit	$25 per visit	20% coinsurance after ded.
Emergency Room	$100 copay after deductible	$150 / visit	$150 / visit	$150 / visit	$150 / visit
Hospitalization	Covered after deductible	Covered after deductible	Covered in full	$500 per admission	20% coinsurance
Day Surgery	Covered after deductible	Covered after deductible	Covered in full	$250 per surgery	20% coinsurance after ded.
Outpatient Care - *Annual Routine Preventative Services*					
• Preventive services	Covered in full	Covered in full	Covered in full	Covered in full	20% coinsurance after ded.
• Routine physical exams (including most preventive screenings), Well-Child Care, Preventive Immunizations, Preventive Pap Smears, Preventive Mammograms & Routine Colonoscopies (Colonoscopies which include any surgical removal will not be considered preventive, and will be subject to the copay, deductible and/or coinsurance).					
• OBGYN visits	Covered after deductible	$25 per visit	$25 per visit	$25 per visit	20% coinsurance after ded.
• Hearing Exam	Covered after deductible	$25 per visit	$25 per visit	$25 per visit	20% coinsurance after ded.
• Allergy shots	Covered after deductible	$5 per visit	$5 per visit	$5 per visit	20% coinsurance after ded.
Non-Routine Services					
• Office Visits	Level 1 provider: $30 copay after deductible is met Level 2 provider: $50 copay after deductible is met	$25 per visit	$25 per visit	Covered in full	20% coinsurance after ded.
• Office Visits – Specialist	Level 1 provider: $30 copay after deductible is met Level 2 provider: $50 copay after deductible is met	$25 per visit – referral req	$25 per visit – referral req	Covered in full	20% coinsurance after ded.
• Diagnostic Test, Lab work, Radiology	Covered after deductible	Covered after deductible	Covered in Full	Covered in full	20% coinsurance after ded.

• High Tech Imaging	Covered after deductible	$75 / max 2 payments per year	$75 / max 2 payments	$75 / max 2 payments	20% coinsurance after ded
• Eye Exam –HPHC network	Covered after deductible	$25 once every 12 months	$25 once every 12 months	$25 once every 12 months	20% coinsurance after ded.
Maternity					
Prenatal/Postnatal Care (routine)	Covered after deductible	Covered in full	Covered in full	Covered in full	20% coinsurance after ded
Office visits	Level 1 provider: $30 copay after deductible is met Level 2 provider: $50 copay after deductible is met	$25 per visit	$25 per visit	$25 per visit	20% coinsurance after ded
Hospitalization/Delivery	Covered after deductible	Covered after deductible	Covered in full	$500 / admission	20% coinsurance after ded.
Mental & Behavioral Health or Substance Abuse Services					
Inpatient	Covered after deductible	Covered after deductible	Covered in full	$500 / admission	20% coinsurance after ded.
Outpatient	$30 copay once deductible is met	$25 / visit	$25 / visit	$25 / visit	20% coinsurance after ded.
Specialized Services					
Habilitative/Rehabilitative Services					
• Short-term physical therapy • occupational therapy	$30 copay after deductible 60 visits per type of therapy	Covered after deductible 60 visits per type of therapy	$25 per visit – 60 visits per type of therapy	$25 per visit – 60 visits per type of therapy	20% coinsurance – 60 visits per type of therapy
• speech therapy	$30 copay once deductible is met	Covered after deductible	$25 per visit – unlimited	$25 per visit – unlimited	20% coinsurance – unlimited
Rehab Hospital Care Prior auth	Covered after deductible -60 days per year	Covered after deductible 60 days per year	Covered in full – 60 days per year	$500 per admission - 60 days per year	$500 per admission after deductible -60 days per year
Skilled Nursing Care Prior auth req	Covered after deductible -100 days per year	Covered after deductible 100 days per year	Covered in full- 100 days per year	$500 per admission - 100 days per year	$500 per admission after deductible -100 days per year
Durable Medical Equipment (DME)/Prosthetics	30% coinsurance after ded.	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance after ded.
Hearing Aids	Deductible, then no charge. Limited to $2,000 per hearing aid every 36 months for each hearing-impaired ear.	No charge. Limited to $2,000 per hearing aid every 36 months, for each hearing-impaired ear. Once the limit is met, there is no additional coverage.	No charge. Limited to $2,000 per hearing aid every 36 months, for each hearing-impaired ear. Once the limit is met, there is no additional coverage.	No charge. Limited to $2,000 per hearing aid every 36 months, for each hearing-impaired ear. Once the limit is met, there is no additional coverage.	20% coinsurance after ded. Limited to the same $2,000 per hearing aid every 36 months, for each hearing-impaired ear.
Chiropractic & Acupuncture Services	$30 copay after deductible	$25 per visit – unlimited visits	$25 per visit – unlimited visits	$25 per visit - unlimited visits	20% coinsurance - unlimited visits

Prescriptions Drugs					
Prescriptions Retail *(up to a 30-day supply)*	$15 after ded. – Tier I $45 after ded. – Tier II $65 after ded. – Tier III	$15 – Tier I $45 – Tier II $65 – Tier III	$15 – Tier I $45 – Tier II $65 – Tier III	$15 – Tier I $45 – Tier II $65 – Tier III	Reimbursable at in network level
Prescriptions Retail (up to a 90 -day supply)	$45 after ded. – Tier I $135 after ded. – Tier II $195 after ded. – Tier III	$45 – Tier I $135 – Tier II $195 – Tier III	$45 – Tier I $135 – Tier II $195 – Tier II	$45 – Tier I $135 – Tier II $195 – Tier II	Reimbursable at in network level
Mail Order Rx Drugs *(up to a 90-day supply)*	$30 after ded. – Tier I $90 after ded. – Tier II $130 after ded. – Tier III	$30 – Tier I $90 – Tier II $130 – Tier III	$30 – Tier I $90 – Tier II $130 – Tier III	$30 – Tier I $90 – Tier II $130 – Tier III	Reimbursable at in network level
Specialty Rx Drugs	$15 after ded. – Tier I $45 after ded. – Tier II $65 after ded. – Tier III	$15 – Tier I $45 – Tier II $65 – Tier III	$15 – Tier I $45 – Tier II $65 – Tier III	$15 – Tier I $45 – Tier II $65 – Tier III	Not Covered
Prescriptions are administered by OptumRx. BIN:610011, PCN: IRX, Group: EDHEALTH. More information available at www. Optumrx.com or 855-546-3439					

Go to the Harvard Pilgrim/Brandeis Microsite's to see the *Schedule of Benefits (SOB)* and *Summary of Benefits and Coverage (SBC*) for each plan for a more comprehensive list of services, service requirements and restrictions. In the event of a discrepancy, the official plan documents will govern.

https://www.harvardpilgrim.org/myoptions/brandeis-university/