Harvard Pilgrim Health Care | Beth Israel Lahey Health

a Point32Health company

2025 Beth Israel Lahey Health Benefit Comparison

	BILH Network Premier HMO		Flex HMO			Flex Plus HMO			Access PPO	
	Tier 1	**Tier 2**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**In-Network**	**Out-of-network**
Annual deductible[1]	$1,000 per member $2,000 per family	$2,500 per member $5,000 per family	$1,000 per member $2,000 per family	$2,500 per member $5,000 per family	$6,000 per member $12,000 per family	$500 per member $1,000 per family	$1,500 per member $3,000 per family	$3,000 per member $6,000 per family	$500 per member $1,000 per family	$2,000 per member $4,000 per family
Annual medical out-of-pocket maximum	$3,000 per member $6,000 per family		$8,000 per member $16,000 per family			$8,000 per member $16,000 per family			$6,000 per member $12,000 per family	
Preventive care visits	No charge		No charge			No charge			No charge	Deductible, then 30% coinsurance
PCP Office visits	No charge	$50 copay (No charge for children up to age 19)	No charge	$50 copay (No charge for children up to age 19)	$80 copay	No charge	$30 copay (No charge for children up to age 19)	$50 copay	$20 copay	Deductible, then 30% coinsurance
Specialist Office visits	$40 copay	$100 copay ($40 copay for children up to age 19)	$40 copay	$100 copay ($40 copay for children up to age 19)	$160 copay	$40 copay	$60 copay ($40 copay for children up to age 19)	$100 copay	$40 copay	Deductible, then 30% coinsurance
Outpatient mental health/substance use disorder treatment (group and individual)	No charge		No charge			No charge			No charge	Deductible, then 30% coinsurance
Inpatient mental health/substance use disorder treatment	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance			Deductible, then 10% coinsurance			Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Emergency room	$200 copay		$200 copay			$200 copay			$150 copay	
Emergency admission	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance			Deductible, then 10% coinsurance			Deductible, then 10% coinsurance	
Urgent care (only HPHC participating urgent care centers)	$40 copay	$100 copay ($40 copay for children up to age 19)	$40 copay	$100 copay ($40 copay for children up to age 19)	$160 copay	$40 copay	$60 copay ($40 copay for children up to age 19)	$100 copay	$40 copay	Deductible, then 30% coinsurance
Hospital inpatient	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance (Deductible, then 10% coinsurance for children up to age 19)	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance (Deductible, then 10% coinsurance for children up to age 19)	Deductible, then 50% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance (Deductible, then 10% coinsurance for children up to age 19)	Deductible, then 40% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance

[1] Amounts applied toward all deductibles will be applied to deductibles in tiers for the HMO plans. The maximum deductible amount paid in one calendar year will not exceed the Tier 3 deductible amount.

Please refer to the Schedule of Benefits and Benefit Handbook for details and a complete list of benefits. The Schedule of Benefits and Benefit Handbook govern in any case in which the information in this document is different.

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	BILH Network Premier HMO		Flex HMO			Flex Plus HMO			Access PPO	
	Tier 1	**Tier 2**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**In-Network**	**Out-of-network**
Day surgery	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance (Deductible, then 10% coinsurance for children up to age 19)	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance (Deductible, then 10% coinsurance for children up to age 19)	Deductible, then 50% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance (Deductible, then 10% coinsurance for children up to age 19)	Deductible, then 40% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Routine Eye Exam (one exam every 12 months)	$40 copay	$100 copay ($40 copay for children up to age 19)	$40 copay	$100 copay ($40 copay for children up to age 19)	$160 copay ($40 copay for children up to age 19)	$40 copay	$60 copay ($40 copay for children up to age 19)	$100 copay ($40 copay for children up to age 19)	$40 copay	Deductible, then 30% coinsurance
Short-Term Outpatient Therapy (PT/OT) (Hospital and non-hospital affiliated – combined limit of 72 visits per calendar year)	$40 copay		$40 copay		$160 copay ($40 copay for children up to age 19)	$40 copay		$100 copay ($40 copay for children up to age 19)	$40 copay	Deductible, then 30% coinsurance
Chiropractic Care (Up to 12 visits per calendar year)	$40 copay		$40 copay		$160 copay	$40 copay		$100 copay	$40 copay	Deductible, then 30% coinsurance
Skilled Nursing Facility (100 days per calendar year)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance			Deductible, then 10% coinsurance			Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Lab/X-ray/diagnostic services and high-end radiology (MRI, CT, PET)										
In physician's office or non-hospital affiliated facility	$40 copay	$100 copay ($40 copay for children up to age 19)	$40 copay	$100 copay ($40 copay for children up to age 19)	$160 copay	$40 copay	$60 copay ($40 copay for children up to age 19)	$100 copay	$40 copay	Deductible, then 30% coinsurance
In hospital or hospital affiliated facility	$40 copay	Deductible, then 30% coinsurance ($40 copay for children up to age 19)	$40 copay	Deductible, then 30% coinsurance ($40 copay for children up to age 19)	Deductible, then 50% coinsurance	$40 copay	Deductible, then 20% coinsurance ($40 copay for children up to age 19)	Deductible, then 40% coinsurance	$40 copay	Deductible, then 30% coinsurance
Prescription drugs										

Harvard Pilgrim does not administer your prescription drug coverage. **ScriptWellRx** administers the prescription drug plan for BILH employees. You can find copay amounts for the BILH plans on the Prescription tab on **Benefits Central**. For more information, please visit **scriptwell.myrxplan.com** or call **ScriptWellRx** at **855-542-1819**.

Please refer to the Schedule of Benefits and Benefit Handbook for details and a complete list of benefits. The Schedule of Benefits and Benefit Handbook govern in any case in which the information in this document is different.