

Emerson College – 2026 Medical Plans Comparison Summary

Plan Feature	Best Buy HMO	Best Buy PPO		Best Buy HSA PPO	
	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$500 per member \$1,000 per family	\$500 per member \$1,000 per family	\$1,000 per member \$2,000 per family	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 per family
Out-of-Pocket Maximum	\$2,500 per member \$5,000 per family	\$2,500 per member \$5,000 per family	\$2,500 per member \$5,000 per family	\$4,000 per member \$8,000 per family	\$8,000 per member \$16,000 per family
Preventive Care					
Annual Routine Physical Exam	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance	Covered in full	Subject to deductible, then 20% coinsurance
Annual Routine Eye Exam	\$25 per visit	\$25 per visit	Subject to deductible, then 20% coinsurance	Covered in full	Subject to deductible, then 20% coinsurance
Well-Child Exam	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance	Covered in full	Subject to deductible, then 20% coinsurance
Outpatient Medical Care					
Non-Routine Office Visits with Primary Care or Specialist	\$25 per visit	Deductible, then \$25 per visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then Level 1 \$30 per visit; Level 2 \$50 per visit after deductible	Subject to deductible, then 20% coinsurance
Diagnostic Imaging (e.g. X-rays, Ultrasounds) & Lab Tests	Subject to deductible, then covered in full	Covered in full	Subject to deductible, then 20% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance
High-Tech Imaging (e.g. MRI, CT, PET and Nuclear Cardiology)	\$75 per procedure, max of \$150 per calendar year	\$75 per procedure, max of \$150 per calendar year	Subject to deductible, then 20% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance
Physical/Occupational/Speech Therapy	Subject to deductible, then covered in full	Subject to deductible, then \$25 per visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then \$30 per visit	Subject to deductible, then 20% coinsurance
Inpatient Hospital Care					
Hospitalization	Subject to deductible, then \$500 per visit	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance
Day Surgery	Subject to deductible, then \$250 per visit	Subject to deductible, then \$250 per visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance

Plan Feature	Best Buy HMO	Best Buy PPO		Best Buy HSA PPO	
	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity Care					
Outpatient Care	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance	Covered in full	Subject to deductible, then 20% coinsurance
Inpatient Care	Subject to deductible, then \$500 per admission	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance
Routine Newborn Inpatient Care	Covered in full	Covered in full	Subject to deductible, then 20% coinsurance	Covered in full	Subject to deductible, then 20% coinsurance
Emergency Care					
Office Visit	\$25 per visit	Subject to deductible, then \$25 per visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then \$30 per visit	Subject to deductible, then 20% coinsurance
Urgent Care	\$25 per visit	Subject to deductible, then \$25 per visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then \$30 per visit	Subject to deductible, then 20% coinsurance
Emergency Room	\$150 per visit (Copayment waived if admitted)	Subject to deductible, then \$150 per visit	Subject to deductible, then \$150 per visit	Subject to deductible, then \$100 per visit	Subject to deductible, then \$100 per visit
Chiropractic Care					
Spinal Manipulation	\$25 per visit	Subject to deductible, then \$25 per visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then \$30 per visit	Subject to deductible, then 20% coinsurance
Mental Health					
Outpatient Care	\$25 per visit	Subject to deductible, then \$25 per visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then \$30 per visit	Subject to deductible, then 20% coinsurance
Inpatient Care	Subject to deductible, then \$500 per admission	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance
Substance Abuse					
Outpatient Care	\$25 per visit	\$25 per visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then \$30 per visit	Subject to deductible, then 20% coinsurance
Inpatient Care	Subject to deductible, then \$500 per admission	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance	Subject to deductible, then covered in full	Subject to deductible, then 20% coinsurance
Durable Medical Equipment					
	20% coinsurance	\$20 coinsurance	Subject to deductible, then 20% coinsurance	Subject to deductible, then 30% coinsurance	Subject to deductible, then 20% 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

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 as well as other member documents.