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ELMET TECHNOLOGIES LLC
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #3 TO THE
JANUARY 1, 2022 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2024

This Plan is amended to include the following updates: In accordance with the requirements of Internal Revenue Code §223, the In-Network and Out-of-Network Individual and Family Deductible and Out-of-Pocket Maximums are revised for the HSA PPO Plan.

This Plan is also amended to include the following updates: update the reference to the primary networks utilized under the plan and to revise the definition of New England: revise the Prescription Drug Benefit to replace ElectRx and CanaRx Programs with AVID Health Program: remove the Co-payment from Routine Vision Exam under the HSA PPO Plan; clarify that precertification requirements for durable medical equipment apply to orthotics; and remove the age limit from the Hearing Aids benefit. In addition, the Plan is also amended to replace the PPO Plan with the PPO Silver Plan and to add a new Plan named PPO Gold Plan. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Document and Summary Plan Description are hereby amended as follows:

SECTION III. DEFINITIONS:

The **Definition of New England** is hereby **deleted** and **replaced** in its entirety with the following:

- **New England –** the states of Massachusetts, New Hampshire and Maine

SECTION IV. SCHEDULE OF MEDICAL BENEFITS:

- The following provision regarding the applicable primary networks utilized under the Plan is hereby **deleted** and **replaced** in its entirety as follows:

  – Primary network for subscribers residing in the 3 New England states and their covered dependents: HPHC
  – Primary network for subscribers residing in the other 47 states and their covered dependents: UnitedHealthcare

  Please note that other networks may apply. Covered Persons should refer to their ID Cards for the network that applies to them.

- **Precertification requirements** for **Orthotics** are **revised** as follows**:**

  – Precertification required as noted under the Durable Medical Equipment benefit

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- **The PPO Plan** is hereby **deleted** and **replaced** in its entirety with a new plan as follows and is named the **PPO Silver Plan**:

PPO Silver Plan

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY FAIROS RX	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments accumulate toward the Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices are covered at 100% Tobacco cessations products are covered at 100%. Preventive Care medications are covered at 100%	**Retail Card Program – You Pay:** (Up to a 30 day supply) $10 Co-payment per generic drug; $30 Co-payment per preferred brand name drug; $50 Co-payment per non-preferred brand name drug **Retail Card Program – You Pay:** (Up to a 90 day supply) $20 Co-payment per generic drug; $60 Co-payment per preferred brand name drug; $100 Co-payment per non-preferred brand name drug **WellDyne Rx Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $20 Co-payment per generic drug; $60 Co-payment per preferred brand name drug; $100 Co-payment per non-preferred brand name drug **Payd Health Rx Specialty Medications – You Pay:** (Up to a 30 day supply) 20% Coinsurance per specialty drug
Out-of-Network Pharmacy Coverage	50% Coinsurance after Out-of-Network Deductible. Claim must be submitted to the Claim Administrator for reimbursement.

AVID HEALTH PROGRAM	
Prescription Drug Mail Order Option for Brand Name Drugs	**AVID Health for Brand medications, You Pay:** $0 Co-payment per script

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MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible	Single Plan (Employee only): $1,250 Family Plan (Employee & family): $1,250 per person, up to $2,500 per family	Single Plan (Employee only): $2,500 Family Plan (Employee & family): $2,500 per person, up to $5,000 per family
Note: The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.		
Reimbursement Percentage ("Coinsurance")	80% of the Contracted Rate (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year	50% of the Allowed Amount* (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year
Calendar Year Out-of-Pocket Maximums (Including all applicable Co-payments, Coinsurance, Calendar Year Deductible and Boston Hospital Benefit Deductible, including those for prescription drugs)	Single Plan (Employee only): $5,000 Family Plan (Employee & family): $5,000 per person, up to $10,000 per family	Family Plan (Employee only): $10,000 Family Plan (Employee & family): $10,000 per person, up to $20,000 per family
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.		
Primary network for subscribers residing in the 3 New England states and their covered dependents: HPHC Primary network for subscribers residing in the other 47 states and their covered dependents: UnitedHealthcare Please note that other networks may apply. Covered Persons should refer to their ID Cards for the network that applies to them.		

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IMPORTANT NOTES:

The In-Network Provider and Out-of-Network Provider Deductible and Out-of-Pocket Maximums are separate and do not accumulate. Eligible expenses which track toward the In-Network Provider Deductible and Out-of-Pocket Maximums will not be credited toward the satisfaction of the Out-of-Network Provider Deductible and Out-of-Pocket Maximums and vice versa.

The following expenses are excluded from the Out-of-Pocket Maximum(s):

- Precertification penalties

*Emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Out-of-Network level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

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PPO Silver Plan

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010 (PPACA). The majority of the PPACA preventive care services recommendations are issued by the U.S. Preventive Service Task Force (USPSTF). These may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided, or a complete listing can be found here. New or updated A and B Recommendations generally go into effect on the first Plan Year one year after issuance of the revised recommendation.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
****Routine Physical Exams** (Including routine immunizations and flu shots)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Well Child Care** (Including screenings, routine immunizations and flu shots)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Fluoride Varnish** (Up to age 6) Up to four (4)* varnish treatments per person, per Calendar Year	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) Breast Pump Limits: • Hospital Grade Breast Pumps: rental covered up to 3 months; *precertification required* for rental in excess of 3 months • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100% (Deductible waived)	50% Allowed Amount (after Deductible)
**** Contraceptive Services and Supplies for Women** (FDA approved only; includes education and counseling)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Pap Smears**	100% (Deductible waived)	50% Allowed Amount (after Deductible)
**** Breast Cancer Screening including Routine Mammograms and BRCA testing** (As recommended by the US Preventive Service Task Force)	100% (Deductible waived)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
One Baseline Mammogram (Age 35 through 39)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Immunizations** (If not billed with an office visit; includes flu shots)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (As recommended by the US Preventive Service Task Force)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (As recommended by the US Preventive Service Task Force) Up to one (1)* per person, per Calendar Year	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Nutritional Counseling**	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Routine Hearing Exams	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings	100% (Deductible waived)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010 (PPACA). The majority of the PPACA preventive care services recommendations are issued by the U.S. Preventive Service Task Force (USPSTF). These may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided, or a complete listing can be found here. New or updated A and B Recommendations generally go into effect on the first Plan Year one year after issuance of the revised recommendation.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
****Abdominal Aortic Aneurysm Screening** (As recommended by the US Preventive Service Task Force) Up to one (1)* per person, per lifetime	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Bone Density Screening** • Women (as recommended by the US Preventive Service Task Force for Osteoporosis Screening) • All other Covered Persons	100% (Deductible waived) 100% (Deductible waived)	50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)

VISION CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Routine Vision Exam (Excludes contact lens fitting) Up to one (1)* exam per person, per Calendar Year	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Eyewear for Special Conditions (Initial purchase of non-routine eyewear following surgery; contact lenses needed to treat keratoconus (including the fitting of these contact lenses); intraocular lenses implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced)	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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PHYSICIAN SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Allergy Testing	80% (after Deductible)	50% Allowed Amount (after Deductible)
Allergy Treatment	80% (after Deductible)	50% Allowed Amount (after Deductible)
Anesthesia (Inpatient/Outpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Chiropractic Services Up to 40* visits per person, per Calendar Year	$30 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Maternity (Includes Physician delivery charges, prenatal and postpartum care, including planned home births)		
• Prenatal care	100% (Deductible waived)	50% Allowed Amount (after Deductible)
• Physician delivery charges	80% (after Deductible)	50% Allowed Amount (after Deductible)
• Postnatal care	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physician Hospital Visits	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physician Office Visits – Primary Care (Includes all related charges billed at time of visit)	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Physician Office Visits - Specialist (Includes all related charges billed at time of visit)	$60 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Second Surgical Opinion	$60 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Surgery (Inpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Surgery (Outpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Surgery (Physician's office)	80% (after Deductible)	50% Allowed Amount (after Deductible)

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HOSPITAL SERVICES – INPATIENT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health – Covered Services billed by these facilities are paid at 100% (Deductible waived).* Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (Deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment. Healthcare Excellence Hubs *Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.* Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Maternity Services *(Precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])* Semi-private room or special care unit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Birthing Center	80% (after Deductible)	50% Allowed Amount (after Deductible)
Newborn Care (Includes Physician visits & circumcision Semi-private room or special care unit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Organ, Bone Marrow and Stem Cell Transplants *(Precertification required; see* Medical Benefits *section for other limitations*) Semi-private room or special care unit Transportation/food/lodging limits: $10,000 per Transplant	80% (after Deductible)	50% Allowed Amount (after Deductible)
Surgical Facility & Supplies	80% (after Deductible)	50% Allowed Amount (after Deductible)
Miscellaneous Hospital Charges	80% (after Deductible)	50% Allowed Amount (after Deductible)

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HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for outpatient inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.**		
HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health – Covered Services billed by these facilities are paid at 100% (Deductible waived).* Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (Deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment. Healthcare Excellence Hubs *Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.* Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency services rendered for "Emergency Care" as defined in the section titled "Definitions"; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Clinic Services (At a Hospital)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Co-payment is waived if admitted on an inpatient basis to a Hospital	$500 Co-payment per admission, then 100% (Deductible waived)	$500 Co-payment per visit, then 100% Allowed Amount (Deductible waived)
Outpatient Department	80% (after Deductible)	50% Allowed Amount (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. (*Precertification required* for total joint replacement and non-emergent spine surgeries)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Preadmission Testing	80% (after Deductible)	50% Allowed Amount (after Deductible)
Urgent Care Facility/ Walk-In Clinic	At Convenient MD Facility: $60 Co-payment per visit, then 100% (Deductible waived) All Other Facilities: $60 Co-payment per visit, then 100% (Deductible waived)	At Convenient MD Facility: 50% Allowed Amount (after Deductible) All Other Facilities: 50% Allowed Amount (after Deductible)

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MENTAL HEALTH/ SUBSTANCE ABUSE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health – Covered Services billed by these facilities are paid at 100% (Deductible waived).* Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (Deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment. Healthcare Excellence Hubs *Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.* Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Inpatient Hospitalization *(Precertification required)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Partial Hospitalization/Intensive Outpatient Treatment *(Precertification required)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Inpatient Physician Visit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hospital Clinic Visit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Office Visit	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Methadone Maintenance/ Treatment	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

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OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health – Covered Services billed by these facilities are paid at 100% (Deductible waived).* Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (Deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment. Healthcare Excellence Hubs *Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.* Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Ambulance Services (*Precertification required* for non-emergent air ambulance services; s*ee* Medical Benefits *section for limitations*)	$150 Co-payment, then 100% (Deductible waived)	$150 Co-payment, then 100% Allowed Amount (Deductible waived)
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); benefit limits do not apply to occupational, physical and speech therapies; precertification *is required* for ABA; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	Benefits are based on services provided	Benefits are based on services provided
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Chemotherapy & Radiation Therapy (*Precertification required* for chemotherapy and intensity-modulated radiation therapy (IMRT), including chemotherapy services administered in a Physician's office; precertification not required for Chemotherapy support drugs	80% (after Deductible)	50% Allowed Amount (after Deductible)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; see Medical Benefits section for other limitations)	Benefits are based on services provided	Benefits are based on services provided

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OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diabetes Self-Management Training and Education	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diagnostic Imaging (MRI, CT Scan, PET Scan)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diagnostic X-ray and Laboratory (Outpatient)	$50 Co-payment, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Dialysis/Hemodialysis *(Precertification required for initial treatment; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Durable Medical Equipment *(Precertification required for* equipment purchase in excess of $1,000 or for equipment rental in excess of three (3) months when cost exceeds $1,000, neuromuscular stimulator equipment, implantable loop recorders and implantable defibrillators (precertification not required for TENS units)*; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Family Planning (Including but not limited to consultations and diagnostic tests)		
For Women (See also Prescription Drug Benefit and Preventive Care Section)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
For Men	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Growth Hormones *(Precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)

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PPO Silver Plan

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Hearing Aids (and related services) Up to $2,000* per aid per hearing impaired ear, every 36 months	80% (after Deductible)	50% Allowed Amount (after Deductible)
Home Health Care *(Precertification required; see* Medical Benefits *section for other limitations)* Up to 80* visits per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hospice Care (Inpatient/Outpatient) *(Precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Injectables *(Precertification required for treatments in excess of $2,000)* Note: *See* Chemotherapy & Radiation Therapy benefit *for other limitations*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Massage Therapy (When recommended by a Physician, with a medical practitioner's (doctor's) note) Up to a maximum of 24* visits per person, per Calendar Year	$35 Co-payment per visit, then 100% (Deductible waived)	$35 Co-payment per visit, then 100% Allowed Amount (Deductible waived)
Medical and Enteral Formula (Including metabolic formula; *precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Neuromuscular Stimulator Equipment including TENS *(Precertification required as noted under the Durable Medical Equipment benefit)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Occupational Therapy (For treatment due to Illness or Injury*;* s*ee* Medical Benefits *section for other limitations*) Up to 60* visits per person, per Calendar Year, combined with Physical Therapy and Speech Therapy	Outpatient Facility**:** $30 Co-payment per visit, then 100% (Deductible waived) Inpatient Facility: 80% (after Deductible)	50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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PPO Silver Plan

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Orthotics (Includes foot orthotics; *precertification required as noted under the Durable Medical Equipment benefit; see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physical Therapy (For treatment due to Illness or Injury*; ;see* Medical Benefits *section for other limitations*) Up to 60* visits per person, per Calendar Year, combined with Occupational Therapy and Speech Therapy	Outpatient Facility**:** $30 Co-payment per visit, then 100% (Deductible waived) Inpatient Facility: 80% (after Deductible)	50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)
Podiatry Care *(See* Medical Benefits *section for limitations*)	$60 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Private Duty Nursing *(Precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Prosthetics *(Precertification required as noted under the Durable Medical Equipment benefit; see* Medical Benefits *section for limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Rehabilitation Hospital *(Precertification required*; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Respiratory Therapy	80% (after Deductible)	50% Allowed Amount (after Deductible)
Skilled Nursing Facility/Extended Care Facility *(Precertification required; see* Medical Benefits *section for other limitations*) Up to 100* days per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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PPO Silver Plan

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Speech Therapy (For treatment due to Illness or Injury; *precertification required*; s*ee* Medical Benefits *section for other limitations)* Up to 60* visits per person, per Calendar Year, combined with Occupational Therapy and Physical Therapy	Outpatient Facility**:** $30 Co-payment per visit, then 100% (Deductible waived) Inpatient Facility: 80% (after Deductible)	50% Allowed Amount (after Deductible)
Telemedicine (Applies to medical and behavioral health services; *see* Medical Benefits *section for additional information*) All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	$25 Co-payment per visit, then 100% (Deductible waived) Paid based on services provided	50% Allowed Amount (after Deductible) Paid based on services provided
Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be put in grave peril by continuing the pregnancy to term)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Voluntary Sterilization **For Women** **For Men**	 100% (Deductible waived) 100% (Deductible waived)	 50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)
Wigs (When hair loss is due to the treatment of cancer or after radiation therapy; s*ee* Medical Benefits *section for other limitations*) Up to $350* per person, every 2 Calendar Years	80% (after Deductible)	50% Allowed Amount (after Deductible)

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WELLNESS BENEFITS	ALL PROVIDERS
Childbirth Classes	100% reimbursement for childbirth classes for each covered expectant mother.

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- A **new plan** called **PPO Gold Plan** is hereby **added** in its entirety as follows:

PPO Gold Plan

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY FAIROS RX	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments accumulate toward the Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices are covered at 100% Tobacco cessations products are covered at 100%. Preventive Care medications are covered at 100%	**Retail Card Program – You Pay:** (Up to a 30 day supply) $10 Co-payment per generic drug; $30 Co-payment per preferred brand name drug; $50 Co-payment per non-preferred brand name drug **Retail Card Program – You Pay:** (Up to a 90 day supply) $20 Co-payment per generic drug; $60 Co-payment per preferred brand name drug; $100 Co-payment per non-preferred brand name drug **WellDyne Rx Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $20 Co-payment per generic drug; $60 Co-payment per preferred brand name drug; $100 Co-payment per non-preferred brand name drug **Payd Health Rx Specialty Medications – You Pay:** (Up to a 30 day supply) 20% Coinsurance per specialty drug
Out-of-Network Pharmacy Coverage	50% Coinsurance after Out-of-Network Deductible. Claims must be submitted to the Claim Administrator for reimbursement.

AVID HEALTH PROGRAM	
Prescription Drug Mail Order Option for Brand Name Drugs	**AVID Health for Brand medications, You Pay:** $0 Co-payment per script

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PPO Gold Plan

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible	Single Plan (Employee only): $500 Family Plan (Employee & family): $500 per person, up to $1,000 per family	Single Plan (Employee only): $1,000 Family Plan (Employee & family): $1,000 per person, up to $2,000 per family
Note: The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.		
Reimbursement Percentage ("Coinsurance")	80% of the Contracted Rate (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year	50% of the Allowed Amount* (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year
Calendar Year Out-of-Pocket Maximums (Including all applicable Co-payments, Coinsurance, Calendar Year Deductible and Healthcare Excellence Hubs Benefit Deductible, including those for prescription drugs)	Single Plan (Employee only): $3,500 Family Plan (Employee & family): $3,500 per person, up to $7,000 per family	Single Plan (Employee only): $7,000 Family Plan (Employee & family): $7,000 per person, up to $14,000 per family
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.		
Primary network for subscribers residing in the 3 New England states and their covered dependents: HPHC Primary network for subscribers residing in the other 47 states and their covered dependents: UnitedHealthcare Please note that other networks may apply. Covered Persons should refer to their ID Cards for the network that applies to them.		

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PPO Gold Plan

IMPORTANT NOTES:

The In-Network Provider and Out-of-Network Provider Deductible and Out-of-Pocket Maximums are separate and do not accumulate. Eligible expenses which track toward the In-Network Provider Deductible and Out-of-Pocket Maximums not be credited toward the satisfaction of the Out-of-Network Provider Deductible and Out-of-Pocket Maximums and vice versa.

The following expenses are excluded from the Out-of-Pocket Maximum(s):

- Precertification penalties

*Emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Out-of-Network level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

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PPO Gold Plan

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010 (PPACA). The majority of the PPACA preventive care services recommendations are issued by the U.S. Preventive Service Task Force (USPSTF). These may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided, or a complete listing can be found here. New or updated A and B Recommendations generally go into effect on the first Plan Year one year after issuance of the revised recommendation.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
****Routine Physical Exams** (Including routine immunizations and flu shots)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Well Child Care** (Including screenings, routine immunizations and flu shots)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Fluoride Varnish** (Up to age 6) Up to four (4)* varnish treatments per person, per Calendar Year	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) Breast Pump Limits: • Hospital Grade Breast Pumps: rental covered up to 3 months; *precertification required* for rental in excess of 3 months • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100% (Deductible waived)	50% Allowed Amount (after Deductible)
**** Contraceptive Services and Supplies for Women** (FDA approved only; includes education and counseling)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Pap Smears**	100% (Deductible waived)	50% Allowed Amount (after Deductible)
**** Breast Cancer Screening including Routine Mammograms and BRCA testing** (As recommended by the US Preventive Service Task Force)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
One Baseline Mammogram (Age 35 through 39)	100% (Deductible waived)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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PPO Gold Plan

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010 (PPACA). The majority of the PPACA preventive care services recommendations are issued by the U.S. Preventive Service Task Force (USPSTF). These may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided, or a complete listing can be found here. New or updated A and B Recommendations generally go into effect on the first Plan Year one year after issuance of the revised recommendation.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
****Routine Immunizations** (If not billed with an office visit; includes flu shots)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (As recommended by the US Preventive Service Task Force)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (As recommended by the US Preventive Service Task Force) Up to one (1)* per person, per Calendar Year	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Nutritional Counseling**	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Routine Hearing Exams	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings	100% (Deductible waived)	50% Allowed Amount (after Deductible)
****Abdominal Aortic Aneurysm Screening** (As recommended by the US Preventive Service Task Force) Up to one (1)* per person, per lifetime	100% (Deductible waived)	50% Allowed Amount (after Deductible)

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VISION CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Routine Vision Exam (Excludes contact lens fitting) Up to one (1)* exam per person, per Calendar Year	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Eyewear for Special Conditions (Initial purchase of non-routine eyewear following surgery; contact lenses needed to treat keratoconus (including the fitting of these contact lenses); intraocular lenses implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced)	80% (after Deductible)	50% Allowed Amount (after Deductible)

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PHYSICIAN SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Allergy Testing	80% (after Deductible)	50% Allowed Amount (after Deductible)
Allergy Treatment	80% (after Deductible)	50% Allowed Amount (after Deductible)
Anesthesia (Inpatient/Outpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Chiropractic Services Up to 40* visits per person, per Calendar Year	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Maternity (Includes Physician delivery charges, prenatal and postpartum care, including planned home births)		
• Prenatal care	100% (Deductible waived)	50% Allowed Amount (after Deductible)
• Physician delivery charges	80% (after Deductible)	50% Allowed Amount (after Deductible)
• Postnatal care	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physician Hospital Visits	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physician Office Visits – Primary Care (Includes all related charges billed at time of visit)	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Physician Office Visits - Specialist (Includes all related charges billed at time of visit)	$50 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Second Surgical Opinion	$50 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Surgery (Inpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Surgery (Outpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Surgery (Physician's office)	80% (after Deductible)	50% Allowed Amount (after Deductible)

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HOSPITAL SERVICES – INPATIENT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and Michigan University Health – Covered Services billed by these facilities are paid at 100% (Deductible waived).* Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (Deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment. *Healthcare Excellence Hubs Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.* Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Maternity Services *(Precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])* Semi-private room or special care unit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Birthing Center	80% (after Deductible)	50% Allowed Amount (after Deductible)
Newborn Care (Includes Physician visits & circumcision Semi-private room or special care unit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Organ, Bone Marrow and Stem Cell Transplants *(Precertification required; see* Medical Benefits *section for other limitations*) Semi-private room or special care unit Transportation/food/lodging limits: $10,000 per Transplant	80% (after Deductible)	50% Allowed Amount (after Deductible)
Surgical Facility & Supplies	80% (after Deductible)	50% Allowed Amount (after Deductible)
Miscellaneous Hospital Charges	80% (after Deductible)	50% Allowed Amount (after Deductible)

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HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for outpatient inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.**		
HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health – Covered Services billed by these facilities are paid at 100% (Deductible waived).* Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (Deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment. *Healthcare Excellence Hubs Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.* Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency services rendered for "Emergency Care" as defined in the section titled "Definitions"; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Clinic Services (At a Hospital)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Co-payment is waived if admitted on an inpatient basis to a Hospital	$500 Co-payment per admission, then 100% (Deductible waived)	$500 Co-payment per visit, then 100% Allowed Amount (Deductible waived)
Outpatient Department	80% (after Deductible)	50% Allowed Amount (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. (*Precertification required* for total joint replacement and non-emergent spine surgeries)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Preadmission Testing	80% (after Deductible)	50% Allowed Amount (after Deductible)
Urgent Care Facility/ Walk-In Clinic	<u>At Convenient MD Facility:</u> $50 Co-payment per visit, then 100% (Deductible waived) <u>All Other Facilities</u>: $50 Co-payment per visit, then 100% (Deductible waived)	<u>At Convenient MD Facility:</u> 50% Allowed Amount (after Deductible) <u>All Other Facilities</u>: 50% Allowed Amount (after Deductible)

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MENTAL HEALTH/ SUBSTANCE ABUSE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health – Covered Services billed by these facilities are paid at 100% (Deductible waived).* Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (Deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment. *Healthcare Excellence Hubs Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.* Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Inpatient Hospitalization *(Precertification required)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Partial Hospitalization/Intensive Outpatient Treatment *(Precertification required)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Inpatient Physician Visit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hospital Clinic Visit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Office Visit	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Methadone Maintenance/ Treatment	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

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OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health – Covered Services billed by these facilities are paid at 100% (Deductible waived).* Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (Deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment. *Healthcare Excellence Hubs Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.* Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Ambulance Services (*Precertification required* for non-emergent air ambulance services; s*ee* Medical Benefits *section for limitations*)	$150 Co-payment, then 100% (Deductible waived)	$150 Co-payment, then 100% Allowed Amount (Deductible waived)
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); benefit limits do not apply to occupational, physical and speech therapies; precertification *is required* for ABA; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	Benefits are based on services provided	Benefits are based on services provided
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Chemotherapy & Radiation Therapy (*Precertification required* for chemotherapy and intensity-modulated radiation therapy (IMRT), including chemotherapy services administered in a Physician's office; precertification not required for Chemotherapy support drugs	80% (after Deductible)	50% Allowed Amount (after Deductible)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; see Medical Benefits section for other limitations)	Benefits are based on services provided	Benefits are based on services provided

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PPO Gold Plan

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diabetes Self-Management Training and Education	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diagnostic Imaging (MRI, CT Scan, PET Scan)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diagnostic X-ray and Laboratory (Outpatient)	$50 Co-payment, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Dialysis/Hemodialysis *(Precertification required for initial treatment; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Durable Medical Equipment *(Precertification required for* equipment purchase in excess of $1,000 or for equipment rental in excess of three (3) months when cost exceeds $1,000, neuromuscular stimulator equipment, implantable loop recorders and implantable defibrillators (precertification not required for TENS units)*; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Family Planning (Including but not limited to consultations and diagnostic tests)		
For Women (See also Prescription Drug Benefit and Preventive Care Section)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
For Men	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Growth Hormones *(Precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hearing Aids (and related services) Up to $2,000* per aid per hearing impaired ear, every 36 months	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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PPO Gold Plan

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Home Health Care *(Precertification required; see* Medical Benefits *section for other limitations)* Up to 80* visits per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hospice Care (Inpatient/Outpatient) *(Precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Injectables *(Precertification required for treatments in excess of $2,000)* Note: *See* Chemotherapy & Radiation Therapy benefit *for other limitations*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Massage Therapy (When recommended by a Physician, with a medical practitioner's (doctor's) note) Up to a maximum of 24* visits per person, per Calendar Year	$25 Co-payment per visit, then 100% (Deductible waived)	$25 Co-payment per visit, then 100% Allowed Amount (Deductible waived)
Medical and Enteral Formula (Including metabolic formula; *precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Neuromuscular Stimulator Equipment including TENS *(Precertification required as noted under the Durable Medical Equipment benefit)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Occupational Therapy (For treatment due to Illness or Injury*; see* Medical Benefits *section for other limitations*) Up to 60* visits per person, per Calendar Year, combined with Physical Therapy and Speech Therapy	Outpatient Facility**:** $25 Co-payment per visit, then 100% (Deductible waived) Inpatient Facility: 80% (after Deductible)	50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)
Orthotics (Includes foot orthotics; *precertification required as noted under the Durable Medical Equipment benefit; see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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PPO Gold Plan

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Physical Therapy (For treatment due to Illness or Injury*; ;see* Medical Benefits *section for other limitations*) Up to 60* visits per person, per Calendar Year, combined with Occupational Therapy and Speech Therapy	Outpatient Facility**:** $25 Co-payment per visit, then 100% (Deductible waived) Inpatient Facility: 80% (after Deductible)	50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)
Podiatry Care *(See* Medical Benefits *section for limitations*)	$50 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Private Duty Nursing *(Precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Prosthetics *(Precertification required as noted under the Durable Medical Equipment benefit; see* Medical Benefits *section for limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Rehabilitation Hospital *(Precertification required*; s*ee* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Respiratory Therapy	80% (after Deductible)	50% Allowed Amount (after Deductible)
Skilled Nursing Facility/Extended Care Facility *(Precertification required; see* Medical Benefits *section for other limitations*) Up to 100* days per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Speech Therapy (For treatment due to Illness or Injury; *precertification required*; *see* Medical Benefits *section for other limitations)* Up to 60* visits per person, per Calendar Year, combined with Occupational Therapy and Physical Therapy	Outpatient Facility**:** $25 Co-payment per visit, then 100% (Deductible waived) Inpatient Facility: 80% (after Deductible)	50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

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PPO Gold Plan

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Telemedicine (Applies to medical and behavioral health services; *see* Medical Benefits *section for additional information*)	$25 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	Paid based on services provided	Paid based on services provided
Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be put in grave peril by continuing the pregnancy to term)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Voluntary Sterilization		
For Women	100% (Deductible waived)	50% Allowed Amount (after Deductible)
For Men	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Wigs (When hair loss is due to the treatment of cancer or after radiation therapy; s*ee* Medical Benefits *section for other limitations*) Up to $350* per person, every 2 Calendar Years	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

WELLNESS BENEFITS	ALL PROVIDERS
Childbirth Classes	100% reimbursement for childbirth classes for each covered expectant mother.

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- **For the HSA PPO Plan,** the following updates are hereby made:

HSA PPO Plan

- The **ElectRx** and **CanaRx Programs** are hereby **deleted** and **replaced** in their entirety with **AVID Health Program** as follows:

AVID HEALTH PROGRAM	
Prescription Drug Mail Order Option for Brand Name Drugs	**AVID Health for Brand medications, You Pay:** $0 Co-payment per script (Deductible Waived)

- **BOSTON HOSPITAL BENEFIT** is hereby **deleted** and **replaced** in its entirety with **HealthCare Excellence Hubs Benefit** as follows:

HEALTHCARE EXCELLENCE HUBS BENEFIT - *Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health – Covered Services billed by these facilities are paid at 100% after satisfaction of the* Healthcare Excellence Hubs *Benefit Deductible (Individual Plan:* **$1,600** *per person; Family Plan:* **$3,200** *per family.*

Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% once the Healthcare Excellence Hubs Benefit Deductible *(Individual Plan:* **$1,600** *per person; Family Plan:* **$3,200** *per family)* has been satisfied, when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment.

Healthcare Excellence Hubs *Travel Benefit - Travel expenses associated with services at out of state facilities listed above will be covered when the Covered Person receiving the services resides more than fifty (50) miles from the facility.*

Commercial transport or equivalent cost to and from for the Covered Person receiving services and one (1) companion. Transportation and lodging are limited to $375 per day per episode of treatment.

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HSA PPO Plan

- The **Deductible** and **Out-of-Pocket Amounts** are hereby **deleted** and **replaced** in their entirety with the following:

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible	Single Plan (Employee only): $2,700 Family Plan (Employee & family): $5,600 per family	Single Plan (Employee only): $5,400 Family Plan (Employee & family): $11,200 per family
For Family Plan members – The entire family Deductible must be satisfied before claims are paid for any covered family member. It may be satisfied by any combination of one or more family members.		
Healthcare Excellence Hubs Benefit Deductible	Single Plan (Employee only): $1,600 Family Plan (Employee & family): $3,200 per family Deductible applies per visit and accumulates to the In-Network Calendar Year Deductible	N/A
Note: Healthcare Excellence Hubs Deductible: Family Plan members – The entire family Deductible must be satisfied before claims are paid for any covered family member. It may be satisfied by any combination of one or more family members.		
Reimbursement Percentage ("Coinsurance")	75% of the Contracted Rate (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year	50% of the Allowed Amount* (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year
Calendar Year Out-of-Pocket Maximums (Including all applicable Co-payments, Coinsurance, Calendar Year Deductible and Boston Hospital Benefit Deductible, including those for prescription drugs)	Single Plan (Employee only): $5,600 Family Plan (Employee & family): $5,600 per person, up to $11,000 per family	Single Plan (Employee only): $11,200 Family Plan (Employee & family): $11,200 per person, up to $22,000 per family
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.		
Primary network for subscribers residing in the 3 New England states and their covered dependents: HPHC Primary network for subscribers residing in the other 47 states and their covered dependents: UnitedHealthcare Please note that other networks may apply. Covered Persons should refer to their ID Cards for the network that applies to them.		

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HSA PPO Plan

- **VISION CARE, Hearings Aids** is hereby **deleted** and **replaced** in its entirety with the following:

OTHER SERVICES & SUPPLIES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Routine Vision Exam (Excludes contact lens fitting) Up to one (1)* exam per person, per Calendar Year	100% (Deductible waived)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

- **OTHER SERVICES, Hearings Aids** is hereby **deleted** and **replaced** in its entirety with the following:

OTHER SERVICES & SUPPLIES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Hearing Aids (and related services) Up to $2,000* per aid per hearing impaired ear, every 36 months	75% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

SECTION V. MEDICAL BENEFITS, A. Benefit Levels; Deductible and **Out-of-Pocket Maximum provisions** are hereby **deleted** and **replaced** in their entirety with the following:

PPO Silver and PPO Gold Plans

Deductible – With respect to a Covered Person, the Deductible for Covered Services rendered by an In-Network Provider or an Out-of-Network Provider in each Calendar Year shall be as shown in the Schedule of Medical Benefits.

The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.

The In-Network and Out-of-Network Deductibles are separate and do not co-accumulate. Eligible In-Network expenses which track toward the In-Network Deductible will not be credited toward satisfaction of the Out-of-Network Deductible and vice versa.

Out-of-Pocket Maximum – The Out-of-Pocket Maximums are shown in the Schedule of Medical Benefits.

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The Family Plan contains both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximum is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximum may be met by any combination of family members.

The Out-of-Pocket Maximum excludes charges in excess of the Allowed Amount and any penalties for failure to follow Preadmission/Precertification Requirements.

The In-Network and Out-of-Network Out-of-Pocket Maximums are separate and do not co-accumulate. Eligible In-Network expenses which track toward the In-Network Out-of-Pocket Maximum will not be credited toward satisfaction of the Out-of-Network Out-of-Pocket Maximum and vice versa.

HSA PPO Plan

Deductible – With respect to a Covered Person, the Deductible for Covered Services rendered by an In-Network Provider or an Out-of-Network Provider in each Calendar Year shall be as shown in the Schedule of Medical Benefits.

The entire family Deductible must be satisfied before claims are paid for any covered family member. It may be satisfied by any combination of family members or by one person.

The In-Network and Out-of-Network Deductibles are separate and do not co-accumulate. Eligible In-Network expenses which track toward the In-Network Deductible will not be credited toward satisfaction of the Out-of-Network Deductible and vice versa.

Out-of-Pocket Maximum – The Out-of-Pocket Maximums are shown in the Schedule of Medical Benefits.

For In-Network Providers, the Family Plan contains both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximum is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximum may be met by any combination of family members.

The Out-of-Pocket Maximum excludes charges in excess of the Allowed Amount and any penalties for failure to follow Preadmission/Precertification Requirements.

The In-Network and Out-of-Network Out-of-Pocket Maximums are separate and do not co-accumulate. Eligible In-Network expenses which track toward the In-Network Out-of-Pocket Maximum will not be credited toward satisfaction of the Out-of-Network Out-of-Pocket Maximum and vice versa.

Accepted by:
Elmet Technologies LLC

DocuSigned by:
Derek Fox
C17CEDF25F534B8...

Authorized Signature	**Title**
Derek Fox	5/31/2024
Print Name	**Date**

CFO

Version 1.0; 05/21/2024