CITY OF WORCESTER | BENEFIT SUMMARY | JULY 1, 2026

<table>
<tr><th rowspan="2">BENEFIT</th><th rowspan="2">HPHC FOCUS</th><th rowspan="2">BCBS NETWORK BLUE SELECT</th><th rowspan="2">HPHC CHOICENET</th><th rowspan="2">BCBS NETWORK BLUE NEW ENGLAND</th><th colspan="2">BCBS BLUE CARE ELECT PREFERRED (FOR THOSE RESIDING OUTSIDE NEW ENGLAND ONLY)</th></tr>
<tr><th>IN-NETWORK</th><th>OUT-OF-NETWORK</th></tr>
<tr><td>DEDUCTIBLE</td><td>$400 IND/$800 FAM</td><td>$500 IND/$1,000 FAM</td><td>$500 IND/$1,000 FAM</td><td>$500 IND/$1,000 FAM</td><td colspan="2">$500 IND/$1,000 FAM</td></tr>
<tr><td>OUT OF POCKET MAXIMUM (INDIVIDUAL/FAMILY)</td><td>$5,000/$10,000 MED
$2,000/$4,000 RX</td><td>$5,000/$10,000 MED
$2,000/$4,000 RX</td><td>$5,000/$10,000 MED
$2,000/$4,000 RX</td><td>$5,000/$10,000 MED
$2,000/$4,000 RX</td><td colspan="2">$5,000/$10,000 MED
$2,000/$4,000 RX</td></tr>
<tr><td>WELLNESS VISIT</td><td>$0</td><td>$0</td><td>$0</td><td>$0</td><td>$0</td><td>20% co-insurance (after deductible)</td></tr>
<tr><td>PCP OFFICE VISIT</td><td>$20 co-pay</td><td>$25 co-pay</td><td>T1: $20 | T2/T3: $25</td><td>T1: $20 | T2: $30 | T3: $40</td><td>$40 co-pay</td><td>20% co-insurance (after deductible)</td></tr>
<tr><td>SPECIALIST VISIT</td><td>$35 co-pay</td><td>$50 co-pay</td><td>T1: $40 | T2/T3: $50</td><td>$50 co-pay</td><td>$50 co-pay</td><td>20% co-insurance (after deductible)</td></tr>
<tr><td>PRESCRIPTIONS</td><td colspan="6">Retail: $10/$30/$60 (30 day supply) | Mail Order: $25/$75/$180 (90 day supply)** (All Plans)</td></tr>
<tr><td>INPATIENT HOSPITAL</td><td>$275 co-pay (after deductible)</td><td>$500 co-pay (after deductible)</td><td>T1: $275 | T2: $500 | T3: $750 (after deductible)</td><td>T1: $275 | T2: $750 ($800 Select, no deductible) | T3: $1,000 (after deductible)</td><td>10% co-insurance (after deductible)</td><td>30% co-insurance (after deductible)</td></tr>
<tr><td>OUTPATIENT SURGERY</td><td>$250 co-pay (after deductible)</td><td>$350 co-pay (after deductible)</td><td>T1: $250 | T2: $350 | T3: $500 (after deductible)</td><td>Surgical day care facility: T1: $250 | T2: $500 ($550 Select, no deductible) | T3: $750 Ambulatory surgical facility: $250 (after deductible)</td><td>Office setting: $50 | Ambu-latory surgical facility: $500 per admit (after deductible)</td><td>20% co-insurance (after deductible)</td></tr>
<tr><td>DIAGNOSTIC SERVICES LAB, X-RAY, ETC.</td><td>Covered in full (after deductible)</td><td>Covered in full (after deductible)</td><td>Covered in full (after deductible)</td><td>Covered in full (after deductible)</td><td>10% co-insurance (after deductible)</td><td>30% co-insurance (after deductible)</td></tr>
<tr><td>CT SCAN, MRI, PET</td><td>$100 co-pay (after deductible)</td><td>$50 non-hospital | $100 hospital (after deductible)</td><td>$100 co-pay (after deductible)</td><td>$100 non-hospital | T1: $100 | T2: $250 | T3: $500 hospital (after deductible)</td><td>10% co-insurance (after deductible)</td><td>30% co-insurance (after deductible)</td></tr>
<tr><td>SHORT-TERM REHAB: OUTPATIENT/OT/PT</td><td>$20 co-pay (after deductible) Up to 60 combined visits per plan year</td><td>$25 co-pay (after deductible) Up to 60 combined visits per plan year</td><td>$25 co-pay (after deductible) Up to 60 combined visits per plan year</td><td>$50 co-pay Up to 60 combined visits per plan year</td><td>$50 co-pay (after deductible) 100 visits per plan year</td><td>20% co-pay (after deductible) 100 visits per plan year</td></tr>
<tr><td>SKILLED NURSING</td><td>Covered in full (after deductible) Up to 100 days per plan year</td><td>Covered in full (after deductible) Up to 100 days per plan year</td><td>Covered in full (after deductible) Up to 100 days per plan year</td><td>Covered in full Up to 100 days per plan year</td><td>10% co-insurance (after deductible) Up to 100 days per plan year</td><td>30% co-insurance (after deductible) Up to 100 days per plan year</td></tr>
<tr><td>CHIROPRACTOR</td><td>$20 co-pay 12 visits per plan year</td><td>$25 co-pay 12 visits per plan year</td><td>$25 co-pay 12 visits per plan year</td><td>$50 co-pay 12 visits per plan year</td><td>$50 co-pay</td><td>20% co-insurance (after deductible)</td></tr>
<tr><td>OUTPATIENT MENTAL HEALTH</td><td>$20 co-pay</td><td>$25 co-pay</td><td>$25 co-pay</td><td>$20 co-pay</td><td>$40 co-pay</td><td>20% co-insurance (after deductible)</td></tr>
<tr><td>DURABLE MEDICAL EQUIPMENT: WHEELCHAIRS/CRUSTCHES/ETC</td><td>20% co-insurance (after deductible)</td><td>20% co-insurance (after deductible)</td><td>20% co-insurance (after deductible)</td><td>20% co-insurance</td><td>20% co-insurance</td><td>40% co-insurance (after deductible)</td></tr>
<tr><td>ER VISIT (WAIVED IT ADMITTED)</td><td>$150 co-pay</td><td>$150 co-pay</td><td>$150 co-pay</td><td>$150 co-pay</td><td>$150 co-pay</td><td>$150 co-pay</td></tr>
<tr><td>AMBULANCE</td><td>Covered in full if medically necessary or when ordered by a physician (after deductible)</td><td>Covered in full if medically necessary or when ordered by a physician (after deductible)</td><td>Covered in full if medically necessary or when ordered by a physician (after deductible)</td><td>Covered in full if medically necessary or when ordered by a physician (no deductible)</td><td>Emergency: 10% co-insurance (no deductible) | Medically necessary: 10% co-insurance (after deductible)</td><td>Emergency: 10% co-insurance (no deductible) | Medically necessary: 30% co -insurance (after deductible)</td></tr>
<tr><td>PREMIUM RATES</td><td></td><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>MONTHLY (IND/FAM)</td><td>$791.60 / $1,988.57</td><td>$990.92 / $2,460.23</td><td>$1,080.85 / $2,683.52</td><td>$1,253.08 / $3,239.63</td><td colspan="2">$1,362.97 / $3,524.16</td></tr>
<tr><td>EMPLOYEE COST</td><td></td><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>WEEKLY (IND/FAM)</td><td>$45.67 / $114.73</td><td>$57.17 / $141.94</td><td>$62.36 / $154.82</td><td>$72.29 / $186.90</td><td colspan="2">$78.63 / $203.32</td></tr>
<tr><td>BI-WEEKLY (IND/FAM)</td><td>$91.34 / $229.45</td><td>$114.34 / $283.87</td><td>$124.71 / $309.64</td><td>$144.59 / $373.80</td><td colspan="2">$157.27 / $406.63</td></tr>
<tr><td>MONTHLY (IND/FAM)</td><td>$197.90 / $497.14</td><td>$247.73 / $615.06</td><td>$270.21 / $670.88</td><td>$313.27 / $809.91</td><td colspan="2">$340.74 / $881.04</td></tr>
</table>

*This is a brief summary of some of the benefits offered. Additional details can be found in the complete plan descriptions.
**Mandatory mail-away for maintenance drugs, or 90-day at retail for maintenance drugs; however, only allowed at CVS pharmacies

BENEFIT	**HPHC BEST BUY TIERED CO-PAY WITH HSA (BROAD NETWORK)**
DEDUCTIBLE	$2,000 IND/$4,000 FAM UNDER THE QHDP, THE CITY WILL CONTINUE CONTRIBUTING HALF OF YOUR DEDUCTIBLE LEVEL TO YOUR HSA ACCOUNT EACH PLAN YEAR (HSA ENROLLMENT REQUIRED)
OUT OF POCKET MAXIMUM (INDIVIDUAL/FAMILY)	$5,000 IND/$10,000 FAM
WELLNESS VISIT	$0
PCP OFFICE VISIT	$20 co-pay (per visit after deductible)
SPECIALIST VISIT	$40 co-pay (per visit after deductible)
PRESCRIPTIONS	Retail 30 Day Supply: $10/$30/$60 (after deductible) Mail Order 90 Day Supply: $25/$75/$180 (after deductible) Deductible waived for certain preventative drugs
INPATIENT HOSPITAL	$275 co-pay (after deductible)
OUTPATIENT SURGERY	$250 co-pay (after deductible)
DIAGNOSTIC SERVICES LAB, X-RAY, ETC.	Covered in full (after deductible)
CT SCAN, MRI, PET	$50 non-hospital | $100 hospital (after deductible)
SHORT-TERM REHAB: OUTPATIENT/OT/PT	$25 co-pay (after deductible) Up to 60 combined visits per plan year
SKILLED NURSING	Covered in full (after deductible) Up to 100 days per plan year
CHIROPRACTOR	$25 co-pay after deductible 12 visits per plan year
OUTPATIENT MENTAL HEALTH	$20 co-pay (after deductible)
DURABLE MEDICAL EQUIPMENT: WHEELCHAIRS/CRUSTCHES/ETC	20% co-insurance (after deductible)
ER VISIT (WAIVED IT ADMITTED)	$150 co-pay (after deductible)
AMBULANCE	Covered in full when ordered by a Physician (after deductible)
PREMIUM RATES	
MONTHLY (IND/FAM)	$770.71 / $1,739.72
EMPLOYEE COST	
WEEKLY (IND/FAM)	$40.43 / $100.37
BI-WEEKLY (IND/FAM)	$80.85 / $200.74
MONTHLY (IND/FAM)	$175.18 / $434.93

*This is a brief summary of some of the benefits offered. Additional details can be found in the complete plan descriptions.
**Eligibility regulations must be met in order to enroll in this plan