Health Insurance Matrix 01/01/26- 12/31/26

Description	Blue Cross Blue Shield Network Blue NE Saver	Blue Cross Blue Shield Network Blue NE Value	Blue Cross Blue Shield Blue Care Elect Deductible
Plan type	HMO - In-Network benefits only	HMO - In-Network benefits only	PPO - In-Network and Out-of-Network benefits
Network	Blue Cross Blue Shield HMO Blue New England	Blue Cross Blue Shield HMO Blue New England	In-Network: Blue Cross Blue Shield BlueCard PPO (National) Out-of-network: All other providers
Primary Care Physician (PCP) referrals required?	Yes. Call 1-800-821-1388 or visit bluecrossma.com/findadoctor and use the *Find a Doctor & Estimate Costs* tool to search for a PCP. PCP referrals are required for specialty care.	Yes. Call 1-800-821-1388 or visit bluecrossma.com/findadoctor and use the *Find a Doctor & Estimate Costs* tool to search for a PCP. PCP referrals are required for specialty care.	No PCP referrals required
Calendar Year Deductibles	For most services, you must meet a deductible before the plan starts to pay: $4,000 for an individual, or $8,000 for a family. If enrolled in a family contract the entire family deductible must be satisfied before Blue Cross Blue Shield will begin to pay claims for any family member.	N/A	In-Network: $1,500 for each member, or $3,000 for all family members covered under the same membership Out-of-Network: $3,000 for each member, or $6,000 for all family members covered under the same membership
HSA Contributions	WPI will contribute $1,800 for an individual, or $4,000 for a family into an HSA account.	N/A	N/A
Calendar Year Out-of- Pocket Maximum: includes all medical and prescription copays, deductible and coinsurance expenses.	$6,000 for each member, or $12,000 for all family members covered under the same membership. Once this is met, the plan pays 100% for the rest of the plan year.	$2,500 for each member, or $5,000 for all family members covered under the same membership. Once this is met, the plan pays 100% for the rest of the plan year.	$5,000 for each member, or $10,000 for all family members covered under the same membership. Once this is met, the plan pays 100% for the rest of the plan year.
Office Visits	Primary Care Physician: 20% coinsurance after deductible Specialist: 20% coinsurance after deductible	Primary Care Physician: $25 copay Specialist: $40 copay	In-Network: Primary Care Physician: $25 copay Specialist: $40 copay Out-of-Network: 20% co-insurance after deductible

Preventive Care ***(Including routine physical, gynecological, well child, routine cancer screenings – e.g., pap smear & colonoscopy)***	Covered in Full	Covered in Full	In-Network: Covered in Full Out-of-Network: 20% co-insurance after deductible
Routine Vision Exam	Covered in Full (one per calendar year)	Covered in Full (one per calendar year)	Covered in Full (one per calendar year)
Mental Health Counseling (Individual Therapy)	20% coinsurance after deductible	$25 copay	In-Network: $25 copay Out-of-Network: 20% co-insurance after deductible
Chiropractic Services	20% coinsurance after deductible	$40 copay	In-Network: $40 copay Out-of-Network: 20% co-insurance after deductible
Acupuncture	20% coinsurance after deductible	$40 copay	In-Network: $40 copay Out-of-Network: 20% co-insurance after deductible
Diagnostic Laboratory and X-Rays	20% coinsurance after deductible	Covered in Full	In-Network: Covered in Full after deductible Out-of-Network: 20% co-insurance after deductible
High Tech Radiology ***(CT Scans, MRIs, and PET Scans)***	20% coinsurance after deductible	$75 copay Copay limited to $150/calendar year	In-Network: Covered in Full after deductible Out-of-Network: 20% co-insurance after deductible

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Emergency Room Visits	20% coinsurance after deductible **All emergency services are covered at the In-Network level**	$150 copay (waived if admitted) **All emergency services are covered at the In-Network level**	$150 copay (waived if admitted) **All emergency services are covered at the In-Network level**
Non-Emergency Hospital Admission	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered
Inpatient Hospital Care & Surgery	20% coinsurance after deductible	$500 copay per admission	In-Network: Covered in Full after deductible Out-of-Network: 20% co-insurance after deductible
Outpatient (Day) Surgery	20% coinsurance after deductible	$250 copay per visit	In-Network: Covered in Full after deductible Out-of-Network: Not Covered
Prescription Drugs *30-Day Retail* (Any participating pharmacy) Coverage through ESI (877-399-5520)	After deductible $15 - Tier 1 $30 - Tier 2 $50 - Tier 3	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3
Prescription Drugs *Smart90* (Any participating pharmacy) Coverage through ESI (877-399-5520)	After deductible $45 - Tier 1 $90 - Tier 2 $150 - Tier 3	$45 - Tier 1 $90 - Tier 2 $150 - Tier 3	$45 - Tier 1 $90 - Tier 2 $150 - Tier 3
Prescription Drugs *Mail Order (90-Day Supply)* Coverage through ESI (877-399-5520)	After deductible $30 - Tier 1 $60 - Tier 2 $100 - Tier 3	$30 - Tier 1 $60 - Tier 2 $100 - Tier 3	$30 - Tier 1 $60 - Tier 2 $100 - Tier 3

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Pediatric Preventive Dental Coverage for Dependent Children Under Age 13 ***(No coverage for adults)***	Covered in Full (two visits per member, per year)	Covered in Full (two visits per member, per year)	Not Covered
Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance	In-Network: 20% coinsurance Out-of-Network: 30% coinsurance after deductible
Wellness Plans	Combined Weight Loss and Fitness Benefit: $150 per year per member; $300 combined maximum	Combined Weight Loss and Fitness Benefit: $150 per year per member; $300 combined maximum	Combined Weight Loss and Fitness Benefit: $150 per year per member; $300 combined maximum

For a complete description of benefits, please refer to your plan certificate (booklet). In case of a discrepancy, the plan certificate will prevail. Please refer to the summary plan description (SPD) for complete details on plan eligibility.