ELEVANTA®
HEALTH

2025-2026
Medical PPO Plans

2025 - 2026 Health Plan Designs & Rates

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ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Platinum Choice Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$500 per individual $1,000 per family	$1,000 per individual $2,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$1,300 per individual $2,600 per family	$2,600 per individual $5,200 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits: One copayment per physician per day.	$20 copayment for PCP $30 copayment for specialist	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$30 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$40 copayment	Deductible; 60%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

ELEVANTA® HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Platinum Choice Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Emergency Services: Copayment waived if admitted.	$150 copayment, deductible; then 80%	$150 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible, 60%
Inpatient Hospital Services:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$20 PCP/$30 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible, 60%
Dialysis Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$20 copayment	Deductible; 60%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
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ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Platinum Choice Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Retail– up to 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then **1-30 day supply:** Generic: $10 copayment Generic Non-Preferred: $20 copayment Preferred Brand: $40 copayment Non-Preferred Brand: $80 copayment **31-90 day supply:** Generic: $30 copayment Generic Non-Preferred: $60 copayment Preferred Brand: $120 copayment Non-Preferred Brand: $240 copayment	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $20 copayment Generic Non-Preferred: $40 copayment Preferred Brand: $80 copayment Non-Preferred Brand: $160 copayment	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then 20% coinsurance up to maximum of $300 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $50 individual/$100 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward in-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Preferred Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$1,500 per individual $3,000 per family	$3,000 per individual $6,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$4,000 per individual $8,000 per family	$8,000 per individual $16,000 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $20 copayment Specialist: $30 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$30 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$50 copayment	Deductible; 60%

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ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Preferred Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Emergency Services: Copayment waived if admitted.	$150 copayment, deductible; then 80%	$150 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible; 60%
Inpatient Hospital Services:	$400 copayment per visit; then deductible and 80%	$400 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$400 copayment per visit; then deductible and 80%	$400 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care:	$400 copayment per visit; then deductible and 80%	$400 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$20 PCP/$30 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$400 copayment per visit; then deductible and 80%	$400 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$20 copayment	Deductible; 60%

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HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Preferred Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Retail– up to 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then **1-30 day supply:** Generic: $20 copayment Generic Non-Preferred: $30 copayment Preferred Brand: $50 copayment Non-Preferred Brand: $100 copayment **31-90 day supply:** Generic: $60 copayment Generic Non-Preferred: $90 copayment Preferred Brand: $150 copayment Non-Preferred Brand: $300 copayment	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $40 copayment Generic Non-Preferred: $60 copayment Preferred Brand: $100 copayment Non-Preferred Brand: $200 copayment	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then 20% coinsurance up to maximum of $400 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $50 individual/$100 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
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8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward In-Network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Basic Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$1,000 per individual $2,000 per family	$2,000 per individual $4,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$7,000 per individual $14,000 per family	$14,000 per individual $28,000 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $25 copayment Specialist: $45 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$45 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$45 copayment	Deductible; 60%

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Major medical plans not available in the state of Minnesota.
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ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Basic Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Emergency Services: Copayment waived if admitted.	$200 copayment, deductible; then 80%	$200 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible; 60%
Inpatient Hospital Services:	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$25 PCP/$45 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$25 copayment	Deductible; 60%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Basic Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Retail– up to a 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then **1-30 day supply:** Generic: $20 copayment Generic Non-Preferred: $30 copayment Preferred Brand: $50 copayment Non-Preferred Brand: $100 copayment **31-90 day supply:** Generic: $60 copayment Generic Non-Preferred: $90 copayment Preferred Brand: $150 copayment Non-Preferred Brand: $300 copayment	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $40 copayment Generic Non-Preferred: $60 copayment Preferred Brand: $100 copayment Non-Preferred Brand: $200 copayment	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then 20% coinsurance up to maximum of $500 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $50 individual/$100 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
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8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
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10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward In-Network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Balanced Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$500 per individual $1,000 per family	$1,500 per individual $3,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, coinsurance, medical copayments, and prescription drug copayments).	$8,500 per individual $17,000 per family	$17,000 per individual $34,000 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits:	Primary Care Physician: $30 copayment Specialist: $50 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$45 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$50 copayment	Deductible; 60%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

ELEVANTA® HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Balanced Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Emergency Services: Copayment waived if admitted.	$150 copayment per visit, then deductible and 80%	$150 copayment per visit, then in-network deductible and 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible; 60%
Inpatient Hospital Services:	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care:	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$25 PCP/$45 Specialist copayment applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Postnatal Maternity Care:	Deductible; 80%	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$30 copayment	Deductible; 60%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold Balanced Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Retail – up to 90 Day Supply)	Deductible: $50 per individual/ $100 per family per plan year; then **1-30 day supply:** Generic: $20 copayment Generic Non-Preferred: $30 copayment Preferred Brand: $50 copayment Non-Preferred Brand: $100 copayment **31-90 day supply:** Generic: $60 copayment Generic Non-Preferred: $90 copayment Preferred Brand: $150 copayment Non-Preferred Brand: $300 copayment	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $40 copayment Generic Non-Preferred: $60 copayment Preferred Brand: $100 copayment Non-Preferred Brand: $200 copayment	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then 20% coinsurance up to maximum of $500 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $50 individual/$100 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward In-Network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold HSA Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services. For two-person or family coverage, expenses incurred by each person accumulates and is credited toward the one family deductible. The Plan will not pay benefits until the family deductible amount has been completely satisfied by any combination of covered participants included under two-person or family coverage.	$1,650 per individual $3,300 per family	$3,300 per individual $6,600 per family
Plan Coinsurance:	80%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, coinsurance, medical copayments, and prescription drug copayments). For two-person or family coverage, expenses incurred by each person accumulates and is credited toward the one family out-of-pocket maximum. The Plan will not pay benefits until the family out-of-pocket maximum amount has been completely satisfied by any combination of covered participants included under two-person or family coverage.	$3,700 per individual $6,900 per family	$7,400 per individual $13,800 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits:	Deductible; 80%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	Deductible; 80%	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 50%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

ELEVANTA® HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold HSA Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 50%
Urgent Care Services:	Deductible; 80%	Deductible; 50%
Emergency Services:	Deductible; 80%	In-network deductible, then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible; 50%
Inpatient Hospital Services:	Deductible; 80%	Deductible; 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	Deductible; 80%	Deductible; 50%
Inpatient Rehabilitation Hospital Care:	Deductible; 80%	Deductible; 50%
Prenatal Maternity Care:	Deductible; 80% applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Postnatal Maternity Care:	Deductible; 80%	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 50%
Durable Medical Equipment:	Deductible; 80%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 50%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 50%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
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ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Gold HSA Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Inpatient Mental Health/Substance Abuse:	Deductible; 80%	Deductible; 50%
Outpatient Mental Health/Substance Abuse:	Deductible; 80%	Deductible; 50%
Prescription Drug Benefit (Retail – up to 90 Day Supply)	Deductible; 80%	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible; 80%	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible; then: 20% coinsurance up to maximum of $500 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 80% in-network and 50% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. For two-person or family coverage, expenses incurred by each person accumulates and is credited toward the one family Deductible. The Plan will not pay benefits until the family Deductible amount has been completely satisfied by any combination of covered participants included under two-person or family coverage.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
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8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward In-Network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA® HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Basic Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$3,000 per individual $6,000 per family	$6,000 per individual $12,000 per family
Plan Coinsurance:	70%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$8,200 per individual $16,400 per family	$16,400 per individual $32,800 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $30 copayment Specialist: $60 copayment	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 70%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	$60 copayment	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 70%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 70%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 70%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 70%	Deductible; 50%
Urgent Care Services:	$75 copayment	Deductible; 50%

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Major medical plans not available in the state of Minnesota.
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ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Basic Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Emergency Services: Copayment waived if admitted.	$250 copayment, deductible; then 70%	$250 copayment, in-network deductible; then 70%
Ambulance Services:	Deductible; 70%	In-Network deductible, then 70%
Anesthesiology Services:	Deductible; 70%	Deductible, 50%
Inpatient Hospital Services:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Inpatient Rehabilitation Hospital Care:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Prenatal Maternity Care:	$30 PCP/$60 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 70%	Deductible; 50%
Durable Medical Equipment:	Deductible; 70%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 70%	Deductible; 50%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Outpatient Mental Health/Substance Abuse:	$30 copayment	Deductible; 50%
Prescription Drug Benefit (Retail– up to 90 Day Supply)	Deductible: $100 per individual/$200 per family per plan year; then 70% coinsurance	Not Covered

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Basic Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $100 per individual/$200 per family per plan year; then 70% coinsurance	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $200 per individual/$400 per family per plan year; then 30% coinsurance up to maximum of $900 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 70% in-network and 50% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $100 individual/$200 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.
8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward In-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Choice Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$2,000 per individual $4,000 per family	$4,000 per individual $8,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$8,000 per individual $16,000 per family	$16,000 per individual $32,000 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $30 copayment Specialist: $50 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$50 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$60 copayment	Deductible; 60%

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Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Choice Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Emergency Services: Copayment waived if admitted.	$200 copayment, deductible; then 80%	$200 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible, 60%
Inpatient Hospital Services:	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care:	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$30 PCP/$50 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$500 copayment per visit; then deductible and 80%	$500 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$30 copayment	Deductible; 60%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Choice Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Retail– up to 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then **1-30 day supply:** Generic: $20 copayment Generic Non-Preferred: $30 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $200 copayment **31-90 day supply:** Generic: $60 copayment Generic Non-Preferred: $90 copayment Preferred Brand: $180 copayment Non-Preferred Brand: $600 copayment	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $40 copayment Generic Non-Preferred: $60 copayment Preferred Brand: $120 copayment Non-Preferred Brand: $400 copayment	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $75 per individual/$150 per family per plan year; then 20% coinsurance to maximum of $900 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $50 individual/$100 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward in-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Balanced Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Providers
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$1,500 per individual $3,000 per family	$3,000 per individual $6,000 per family
Plan Coinsurance:	70%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, coinsurance, medical copayments, and prescription drug copayments).	$8,200 per individual $16,400 per family	$16,400 per individual $32,800 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $60 copayment Specialist: $75 copayment	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 70%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	$75 copayment	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 70%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 70%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 70%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 70%	Deductible; 50%
Urgent Care Services:	$75 copayment	Deductible; 50%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Balanced Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Emergency Services: Copayment waived if admitted.	$200 copayment per visit; then deductible and 70%	$200 copayment per visit,; then in-network deductible and 70%
Ambulance Services:	Deductible; 70%	In-Network deductible, then 70%
Anesthesiology Services:	Deductible; 70%	Deductible, 50%
Inpatient Hospital Services:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Inpatient Rehabilitation Hospital Care:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Prenatal Maternity Care:	$60 PCP/$75 Specialist copayment applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Postnatal Maternity Care:	Deductible; 70%	Deductible, 50%
Hospice Facility/Home Hospice:	Deductible; 70%	Deductible; 50%
Durable Medical Equipment:	Deductible; 70%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 70%	Deductible; 50%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Outpatient Mental Health/Substance Abuse:	$60 copayment	Deductible; 50%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
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2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver Balanced Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Retail– up to 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then **1-30 day supply:** Generic: $20 copayment Generic Non-Preferred: $30 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $100 copayment **31-90 day supply:** Generic: $60 copayment Generic Non-Preferred: $90 copayment Preferred Brand: $180 copayment Non-Preferred Brand: $300 copayment	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $40 copayment Generic Non-Preferred: $60 copayment Preferred Brand: $120 copayment Non-Preferred Brand: $200 copayment	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $100 per individual/$200 per family per plan year; then 20% coinsurance up to maximum of $900 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 70% in-network and 50% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $50 individual/$100 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
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8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward In-Network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver HSA Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$3,300 per individual $6,600 per family	$6,600 per individual $13,200 per family
Plan Coinsurance:	80%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, medical copayments, and prescription drug copayments).	$6,900 per individual $13,300 per family	$13,800 per individual $26,600 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits: One copayment per physician per day.	Deductible; 80%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	Deductible; 80%	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 50%
Urgent Care Services:	Deductible; 80%	Deductible; 50%
Emergency Services:	Deductible; 80%	In-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible, 50%
Inpatient Hospital Services:	Deductible; 80%	Deductible, 50%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
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2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver HSA Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Skilled Nursing Facility: Maximum of 100 days per plan year.	Deductible; 80%	Deductible, 50%
Inpatient Rehabilitation Hospital Care:	Deductible; 80%	Deductible, 50%
Prenatal Maternity Care:	Deductible; 80% applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 50%
Durable Medical Equipment:	Deductible; 80%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 50%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	Deductible; 80%	Deductible; 50%
Outpatient Mental Health/Substance Abuse:	Deductible; 80%	Deductible; 50%
Prescription Drug Benefit (Retail– up to 90 Day Supply)	Deductible; 80%	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible; 80%	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible; then: 20% coinsurance to maximum of $900 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 80% in-network and 50% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
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2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Silver HSA Plan

6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
8. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
9. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward in-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze Preferred Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$4,000 per individual $8,000 per family	$8,000 per individual $16,000 per family
Plan Coinsurance:	70%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, coinsurance, medical copayments, and prescription drug copayments).	$8,500 per individual $17,800 per family	$17,800 per individual $35,600 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits:	Primary Care Physician: $40 copayment Specialist: $60 copayment	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 70%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	$60 copayment	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 70%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 70%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 70%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 70%	Deductible; 50%
Urgent Care Services:	$75 copayment	Deductible; 50%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

ELEVANTA® HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze Preferred Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Emergency Services: Copayment waived if admitted.	$300 copayment per visit; then deductible and 70%	$300 copayment per visit; then in-network deductible and 70%
Ambulance Services:	Deductible; 70%	In-Network deductible, then 70%
Anesthesiology Services:	Deductible; 70%	Deductible; 50%
Inpatient Hospital Services:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Inpatient Rehabilitation Hospital Care:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Prenatal Maternity Care:	$40 PCP/$60 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 70%	Deductible; 50%
Durable Medical Equipment:	Deductible; 70%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 70%	Deductible; 50%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	$500 copayment per visit; then deductible and 70%	$500 copayment per visit; then deductible and 50%
Outpatient Mental Health/Substance Abuse:	$40 copayment	Deductible; 50%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
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2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze Preferred Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Retail – up to 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then **1-30 day supply:** Generic: $25 copayment Generic Non-Preferred: $35 copayment Preferred Brand: $65 copayment Non-Preferred Brand: $150 copayment **31-90 day supply:** Generic: $75 copayment Generic Non-Preferred: $105 copayment Preferred Brand: $195 copayment Non-Preferred Brand: $450 copayment	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $50 copayment Generic Non-Preferred: $70 copayment Preferred Brand: $130 copayment Non-Preferred Brand: $300 copayment	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $100 per individual/$200 per family per plan year; then 20% coinsurance up to maximum of $900 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

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3. All other covered benefits not listed above will be subject to Deductible, then payable at 70% in-network and 50% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $50 individual/$100 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.
8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.

9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward in-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA® HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze Basic Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$5,500 per individual $11,000 per family	$11,000 per individual $22,000 per family
Plan Coinsurance:	50%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, coinsurance, medical copayments, and prescription drug copayments).	$9,200 per individual $18,400 per family	$18,900 per individual $37,800 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits:	Deductible; 50%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 50%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	$60 copayment	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 50%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 50%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 50%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 50%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 50%	Deductible; 50%
Urgent Care Services:	Deductible; 50%	Deductible; 50%
Emergency Services: Copayment waived if admitted.	$350 copayment per visit; then deductible and 50%	$350 copayment per visit; then in-network deductible and 50%

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Major medical plans not available in the state of Minnesota.
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ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze Basic Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Ambulance Services:	Deductible; 50%	In-Network deductible, then 50%
Anesthesiology Services:	Deductible; 50%	Deductible; 50%
Inpatient Hospital Services:	$500 copayment per visit; then deductible and 50%	$500 copayment per visit; then deductible and 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$500 copayment per visit; then deductible and 50%	$500 copayment per visit; then deductible and 50%
Inpatient Rehabilitation Hospital Care:	$500 copayment per visit; then deductible and 50%	$500 copayment per visit; then deductible and 50%
Prenatal Maternity Care:	Deductible; 50% applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 50%	Deductible; 50%
Durable Medical Equipment:	Deductible; 50%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 50%	Deductible; 50%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 50%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	$500 copayment per visit; then deductible and 50%	$500 copayment per visit; then deductible and 50%
Outpatient Mental Health/Substance Abuse:	Deductible; 50%	Deductible; 50%
Prescription Drug Benefit (Retail – up to 90 Day Supply)	Deductible: $250 per individual/$500 per family per plan year; then 50% coinsurance	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $250 per individual/$500 per family per plan year; then 50% coinsurance	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible: $500 per individual/$1000 per family per plan year; then 50% coinsurance to maximum of $900 per script	Not Covered

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Major medical plans not available in the state of Minnesota.
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2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze Basic Plan

DIABETES PROGRAM	
Livongo Diabetes Management Program	100%, no deductible

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 50%.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. The $250 individual/$500 family prescription drug plan year Deductible is a combined Deductible for both retail and mail order prescriptions.
8. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
9. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
10. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward in-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze HSA Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$6,650 per individual $13,300 per family	$13,300 per individual $26,600 per family
Plan Coinsurance:	100%	80%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, coinsurance, medical copayments, and prescription drug copayments).	$7,150 per individual $14,300 per family	$15,000 per individual $30,000 per family
Preventive Services:	100%	Deductible; 80%
Physician's Office Visits:	Deductible; 100%	Deductible; 80%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	Deductible; 80%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 100%	Deductible; 80%
Chiropractic Care: Maximum of $1,000 per plan year.	Deductible; 100%	Deductible; 80%
Outpatient Diagnostic Laboratory Services:	Deductible; 100%	Deductible; 80%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 100%	Deductible; 80%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 100%	Deductible; 80%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 100%	Deductible; 80%
Outpatient Private Duty Nursing:	Deductible; 100%	Deductible; 80%

The Elevanta Health major medical plans utilize the National BlueCard® PPO Network. Participating physician and hospital information can be obtained via provider.bcbs.com. All employee contributions should be made on a pretax basis. Renewal date of the program will be May 1.
Major medical plans not available in the state of Minnesota.
Elevanta Health Major Medical plan grids shown here offer a summary of the plans. Please refer to the Summary Plan Description (SPD) for further details.

ELEVANTA®
HEALTH

2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze HSA Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Urgent Care Services:	Deductible; 100%	Deductible; 80%
Emergency Services:	Deductible; 100%	In-network deductible and 100%
Ambulance Services:	Deductible; 100%	In-Network deductible, then 100%
Anesthesiology Services:	Deductible; 100%	Deductible; 80%
Inpatient Hospital Services:	Deductible; 100%	Deductible; 80%
Skilled Nursing Facility: Maximum of 100 days per plan year.	Deductible; 100%	Deductible; 80%
Inpatient Rehabilitation Hospital Care:	Deductible; 100%	Deductible; 80%
Prenatal Maternity Care:	Deductible; 100% applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 80%
Hospice Facility/Home Hospice:	Deductible; 100%	Deductible; 80%
Durable Medical Equipment:	Deductible; 100%	Deductible; 80%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 100%	Deductible; 80%
Dialysis: Maximum of 25 visits per plan year.	Deductible; 100%	Deductible; 80%
Inpatient Mental Health/Substance Abuse:	Deductible; 100%	Deductible; 80%
Outpatient Mental Health/Substance Abuse:	Deductible; 100%	Deductible; 80%

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Major medical plans not available in the state of Minnesota.
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2025-2026 Major Medical PPO Plan
Schedule of Medical Benefits
Bronze HSA Plan

Benefit	In-Network / Preferred Provider Network / BlueCard®	Out-of-Network / Non-Preferred Provider
Prescription Drug Benefit (Retail – up to 90 Day Supply)	Deductible; 100%	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible; 100%	N/A
Prescription Drug Benefit (Specialty – 30-Day Supply)	Deductible; then: 50% coinsurance to maximum of $900 per script	Not Covered
DIABETES PROGRAM		
Livongo Diabetes Management Program	100%, no deductible	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "Preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 100% in-network and 80% out-of-network.
4. All in and out-of-network benefit limits are combined.
5. All in and out-of-network Deductible and Coinsurance amounts are not combined.
6. All medical and prescription drug Copayments are applied to the Out-of-Pocket Maximum.
7. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
8. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
9. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider

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Major medical plans not available in the state of Minnesota.
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and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward in-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

2025-2026 Medical PPO Plan
Schedule of Medical Benefits
MEC Choice Plan

Benefit	
INPATIENT CARE (PER DIEM BENEFIT)	
Daily Hospital Confinement Requires pre-certification.	Plan pays $2,000 per day $4,000 per day for ICU
Inpatient Mental Health/Substance Abuse Requires pre-certification.	Plan pays $200 per day
Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility Requires pre-certification.	Plan pays $200 per day
Anesthesia Services	Plan pays $300 per day
Inpatient	Plan pays $3,000 per surgery
Outpatient	Plan pays $2,000 per surgery
Office Visit	Plan pays $175 per surgery
PHYSICIAN'S SERVICES (PER VISIT BENEFIT)	
Preventive Care (only covered when received from an in-network provider)	Plan pays 100% See Schedule on page 8
Physician's Office Visits (Non-Wellness)	Plan pays $60 per visit
Specialist Office Visits (Non-Wellness)	Plan pays $80 per visit
Chiropractic Care	Plan pays $35 per visit
Outpatient Physical Therapy	Plan pays $35 per visit
EMERGENCY CARE	
Ambulance Services	Plan pays $150 (Ground) $750 (Air)

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ELEVANTA®
HEALTH

2025-2026 Medical PPO Plan
Schedule of Medical Benefits
MEC Choice Plan

EMERGENCY CARE continued	
Emergency Room Services	Plan pays $200 per visit
Urgent Care Services	Plan pays $60 per visit
OUTPATIENT DIAGNOSTIC IMAGING (PER SERVICE BENEFIT)	
Labs	Plan pays $15 per service
X-Ray/Ultrasound	Plan pays $75 per service
PET	Plan pays $225 per service
CT Scan	Plan pays $300 per service
MRI	Plan pays $500 per service
PRESCRIPTION DRUGS – UP TO 90 DAY SUPPLY RETAIL; 90 DAY SUPPLY MAIL ORDER (PER SCRIPT BENEFIT)	
Prescription Drug Benefits	**1-30 day supply retail & 90 day supply mail order** Plan pays up to $15 per script - Generic Plan pays up to $75 per script - Preferred Brand Plan pays up to $100 per script – Non-Preferred Brand **31-90 day supply retail:** Plan pays up to $45 per script - Generic Plan pays up to $225 per script - Preferred Brand Plan pays up to $300 per script – Non-Preferred Brand

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit. Preventive care benefits are only covered when received from an in-network provider.
3. All other benefits not listed above will not be covered.
4. The Plan pays up to the dollar amount listed on the Schedule of Benefits. With the exception of prescription drug benefits, if reimbursement to the provider totals less than the dollar amounts listed, the covered person will be reimbursed the difference.

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ELEVANTA® HEALTH

2025-2026 Medical PPO Plan
Schedule of Medical Benefits
MEC Basic Plan

Benefit	
INPATIENT CARE (PER DIEM BENEFIT)	
Daily Hospital Confinement	Plan pays $450 per day $900 per day for ICU
Inpatient Mental Health/Substance Abuse	Plan pays $100 per day
Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility	Plan pays $100 per day
Anesthesia Services	Plan pays $100 per day
SURGERY (PER SURGERY BENEFIT)	
Inpatient	Plan pays $1,000 per surgery
Outpatient	Plan pays $500 per surgery
Office Visit	Plan pays $100 per surgery
PHYSICIAN'S SERVICES (PER VISIT BENEFIT)	
Preventive Care (only covered when received from an in-network provider)	Plan pays 100% See Schedule on page 8
Physician's Office Visits (Non-Wellness)	Plan pays $40 per visit
Specialist Office Visits (Non-Wellness)	Plan pays $60 per visit
Chiropractic Care	Plan pays $25 per visit
Outpatient Physical Therapy	Plan pays $25 per visit
EMERGENCY CARE	
Ambulance Services	Plan pays $100 (Ground) $500 (Air)
Emergency Room Services	Plan pays $75 per visit
Urgent Care Services	Plan pays $40 per visit

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Major medical plans not available in the state of Minnesota.
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2025-2026 Medical PPO Plan
Schedule of Medical Benefits
MEC Basic Plan

OUTPATIENT DIAGNOSTIC IMAGING (PER SERVICE BENEFIT)	
Labs	Plan pays $10 per service
X-Ray/Ultrasound	Plan pays $50 per service
PET	Plan pays $150 per service
CT Scan	Plan pays $200 per service
MRI	Plan pays $350 per service
PRESCRIPTION DRUGS – UP TO 90 DAY SUPPLY RETAIL; 90 DAY SUPPLY MAIL ORDER (PER SCRIPT BENEFIT)	
Prescription Drug Benefits	**1-30 day supply retail & 90 day supply mail order** Plan pays up to $10 per script – Generic Plan pays up to $25 per script – Preferred Brand Plan pays up to $40 per script - Non-Preferred Brand **31-90 day supply retail:** Plan pays up to $30 per script – Generic Plan pays up to $75 per script – Preferred Brand Plan pays up to $120 per script - Non-Preferred Brand

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit. Preventive care benefits are only covered when received from an in-network provider.
3. All other benefits not listed above will not be covered.
4. The Plan pays up to the dollar amount listed on the Schedule of Benefits. With the exception of prescription drug benefits, if reimbursement to the provider totals less than the dollar amounts listed, the covered person will be reimbursed the difference.

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