Hologic Medical Plans At-a-Glance

Effective July 1, 2024	CDHP with HSA		PPO		PPO Plus	
Medical (through Blue Cross Blue Shield of MA)	**In-network You Pay**	**Out-of-network You Pay**	**In-network You Pay**	**Out-of-network You Pay**	**In-network You Pay**	**Out-of-network You Pay**
Hologic annual contribution to Health Savings Account (through HealthEquity)	$700 - employee only / $1,400 - family Prorated and funded per pay period		N/A	N/A	N/A	N/A
Plan year deductible	$1,600 employee only[1] $3,200 family[1]	$3,500 employee only[1] $7,000 family[1]	$1,000 per person $2,000 per family[2]	$2,250 per person $4,500 per family[2]	$750 per person $1,500 per family[2]	$1,250 per person $2,500 per family[2]
Plan year out-of-pocket maximum (OOP)	$3,200 employee only[3] $6,400 family[3]	$6,000 employee only[3] $12,000 family[3]	$3,500 per person $7,000 family[5]	$4,500 per person $9,000 family[5]	$2,500 per person $5,000 per family[5]	$4,000 per person $8,000 family[5]
Preventive visits (i.e. well-child care, adult preventive exams)	No cost	40%[4]	No cost	40%[4]	No cost	40%[4]
Primary care office visit (non-preventive visits)	15%[4]	40%[4]	$30 copay[4]	40%[4]	$25 copay[4]	40%[4]
Other covered providers (specialists) office visit	15%[4]	40%[4]	$50 copay[4]	40%[4]	$40 copay[4]	40%[4]
Telehealth (virtual office visit)	No cost[4]	40%[4]	No cost	40%[4]	No cost	40%[4]
Breast Health Imaging (Ultrasound/MRI/CT & PET scans)	No cost[4]	40%[4]	No cost	40%[4]	No cost	40%[4]
Diagnostic X-ray, lab tests and other tests (any setting)	15%[4]	40%[4]	20%[4]	40%[4]	10%[4]	40%[4]
MRIs/CT scans/PET scans/nuclear cardiac imaging tests	15%[4]	40%[4]	20%[4]	40%[4]	10%[4]	40%[4]
Inpatient hospital	15%[4]	40%[4]	20%[4]	40%[4]	10%[4]	40%[4]
Chiropractic care (90 visits per calendar year)	15%[4]	40%[4]	$50 copay[4]	40%[4]	$40 copay[4]	40%[4]
Emergency room	15%; in-network deductible applies only		$150 per visit; no deductible		$150 per visit; no deductible	
Outpatient behavioral health/substance abuse treatment	15%[4]	40%[4]	$30 copay[4]	40%[4]	$25 copay[4]	40%[4]
Prescription drugs (through CVS Caremark)	**In-Network coverage only** Retail: 30-day supply Maintenance Choice: 90-day supply[7] Mail Order: 90-day supply		**In-Network coverage only** Retail: 30-day supply Maintenance Choice: 90-day supply[7] Mail Order: 90-day supply		**In-Network coverage only** Retail: 30-day supply Maintenance Choice: 90-day supply[7] Mail Order: 90-day supply	
Plan year out-of-pocket maximum (OOP) (Applies to Prescription Drugs only)	A separate prescription out-of-pocket maximum (OOP) does not apply. Combined with medical OOP maximum.		$3,500 per person[8] $7,000 family[8]		$2,500 per person[8] $5,000 per family[8]	
• **Generic (Tier 1)**	$10 copay[6]/$20 copay[6]		$10 copay/$20 copay		$10 copay/$20 copay	
• **Preferred brand name (Tier 2)**	You pay 25%[6]		$30 copay/$60 copay		$30 copay/$60 copay	
• **Non-preferred brand name (Tier 3)**	You pay 35%[6]		$50 copay/$100 copay		$50 copay/$100 copay	
• **Specialty Medication (Tier 4)**	See Tier 2 or 3 coinsurance – Or $0 with PrudentRx[9]		$150 copay – Or $0 with PrudentRx[9]		$150 copay – Or $0 with PrudentRx[9]	

Employee Contributions

	CDHP with HSA		PPO		PPO Plus	
	Bi-Weekly	**Semi-Monthly**	**Bi-Weekly**	**Semi-Monthly**	**Bi-Weekly**	**Semi-Monthly**
• **Employee only**	$32.56	$35.27	$54.87	$59.45	$122.85	$133.09
• **Employee + 1 dependent**	$91.17	$98.77	$124.83	$135.24	$252.93	$274.01
• **Employee + family**	$136.76	$148.16	$187.25	$202.85	$379.39	$411.01

1 **CDHP with HSA:** The entire deductible must be satisfied before benefits are paid.
2 **PPO and PPO Plus:** The family deductible can be satisfied by eligible costs incurred by any combination of covered family members. No individual family member will have to pay more than the per person deductible before benefits are provided for that family member.
3 **CDHP with HSA:** The out-of-pocket maximum must be satisfied before any covered member receives 100% coverage for the remainder of a plan year, including prescription drugs.
4 After plan year deductible is met
5 **PPO and PPO Plus:** The family plan year out-of-pocket maximum can be satisfied by eligible medical costs incurred by any combination of covered family members. No individual family member will have to pay more than the per person out-of-pocket maximum before that family member receives 100% medical coverage for the remainder of the plan year, excluding prescription drugs.
6 **CDHP with HSA only:** Some preventive drugs are not subject to the medical plan year deductible.
7 If you fill a prescription at a CVS Caremark retail pharmacy, you may get a 90-day supply for a cost of a 60-day supply when enrolled in the PPO or PPO Plus plan and a discount when enrolled in the CDHP plan.
8 **PPO and PPO Plus:** The cost of prescription drugs will apply to a separate prescription drugs out-of-pocket maximum.
9 The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs therefore lowering the out-of-pocket cost

Hologic Dental Plans At-a-Glance

Effective July 1, 2024	CORE Plan		ENHANCED Plan	
Dental (through Delta Dental of MA)	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Plan Year Maximum (7/1 – 6/30):	$750[1&2]		$2,000[1&2]	
Plan Year Deductible (7/1 – 6/30): **Individual/Family** (Waived for Diagnostic and Preventive categories)	$100 per person[1] $300 per family[1]		$50 per person[1] $150 per family[1]	
Category	**Coverage Level**			
Diagnostic (such as, oral exam and x-rays) **Preventative** (such as, cleanings, fluoride treatments and sealants)	100%[3]	100%[4]	100%[3]	100%[4]
Basic Restorative (such as fillings) **Oral Surgery** (such as extractions) **Endodontics** (such as root canals) **Prosthetic Maintenance** (such as bridge, denture or crown repair **Emergency Dental Care**	80%	80%[4]	80%	80%[4]
Periodontics (on natural teeth only, such as surgery, scaling/root planning and cleaning[5])	80% / $100%	80% / 100%[4]	80% / 100%	80% / 100%[4]
Major Restorative (Prosthodontic and other services) including Dentures, Bridges, Crowns and Implants	50%	50%[4]	60%	60%[4]
Orthodontics (Child and Adult coverage)	Not covered		50%[1] $2,500 per person[6] Lifetime Maximum	
Rollover Maximum (Does not apply to Orthodontic services) To qualify for Rollover Maximum, you must receive at least one cleaning or oral evaluation in the plan year	$750[1]		$2,500[1]	
• **If your total yearly claims do not exceed this threshold amount** • **Then you can rollover this amount into the next plan year** • **Your accumulated rollover total is capped at this amount**	$300[1] $200[1] $500[1]		$800[1] $600[1] $1,500[1]	
Right Start 4 Kids[7] (age 12 and under)	No deductible: 100% coverage for diagnostic, preventive, basic & major services up to the plan year maximum[7]		No deductible: 100% coverage for diagnostic, preventive, basic & major services up to the plan year maximum[7]	
	Employee Contributions			
	CORE Plan		**ENHANCED Plan**	
	Bi-Weekly	**Semi-Monthly**	**Bi-Weekly**	**Semi-Monthly**
• **Employee only** • **Employee + 1 dependent** • **Employee + family**	$3.65 $6.97 $10.22	$3.96 $7.55 $11.08	$8.51 $16.26 $23.83	$9.22 $17.61 $25.82

1 Combined in and out of network.
2 The plan year maximum is the amount Delta Dental will pay for covered services in the plan year. Once the plan year maximum is met, the member is responsible for paying 100% of costs for any additional dental services in the plan year.
3 Cost does not count towards the plan year maximum.
4 Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum fee allowance and the full fee charged by the non-participating dentist.
5 Periodontal cleanings: 4 per plan year following active periodontal treatment. Not combined with preventive cleanings.
6 The Orthodontic lifetime maximum does not count towards the plan year maximum.
7 Does not apply to orthodontics. Annual benefit maximum applies. Non-participating dentists may balance bill.
NOTE: Eligible dependents are covered up to the end of the month in which they turn age 26.