Employee Benefit Summary – Advantage Savings Plus Plan
Network: National PPO (BlueCard PPO) Network
Effective Date: 1/1/2026

Benefit	In-Network	Out-Of-Network
Plan Deductible	$6,550 Individual $13,100 Family	$8,550 Individual $17,100 Family
Any Other Deductible	N/A	N/A
Deductible – Accumulation	Embedded	Embedded
Deductible – INN and OON integration	In-Network and Out-of-Network Accumulate Separately	
Member Coinsurance	0% - 40% Depending on Benefit	50%
Out of Pocket Maximum	$9,200 Individual $9,200 Individual in a Family $18,400 Family	$16,300 Individual $16,300 Individual in a Family $32,600 Family
Out of Pocket – Accumulation	Embedded	Embedded
Out of Pocket – INN and OON integration	In-Network and Out-of-Network Accumulate Separately	
Annual Benefit Maximum	Unlimited	Unlimited
Benefit Period	Calendar Year	1/1 - 12/31

Savings Plus Plan benefit payment pricing of 150% of the Medicare Allowable rate applies to the following In-Network services: All in-patient and out-patient facility services; All in-patient professional and ancillary services; Surgical services – in a hospital in-patient and out-patient setting; Surgical services – in an ambulatory or free-standing surgical facility setting; All emergency services; Ambulance services - air, ground, and water; High cost diagnostic services, imaging, sleep management studies, and genetic services; dialysis/hemodialysis – all settings, all services; Infusion services – all settings, all services.
If an Out-Of-Network provider is used for these services, with the exception of Emergency Medical services and Emergency Transportation, plan payment will be based on 120% of the Medicare allowable rate.

Preventive Medical Services

Benefit	In-Network	Out-Of-Network
Primary Care Physician Office: Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Pediatrician - Well Child Care: Up to age 2 - 9 visits per plan year Age 2 – 2 visits per plan year Age 3 and more – 1 visit per plan year	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Children Eye Exam	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Gynecological - Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Maternity (ACA Required Prenatal /Postnatal Testing/Services only)	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Routine Immunizations (Child & Adult)	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Flu Shot (Routine)	No Charge (Deductible Waived)	50% Coinsurance after Deductible
X-Rays and Lab tests (Routine)	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Mammography (Routine) – 1 per plan year; Age 40 and more	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Pap-smear (Routine) – 1 per plan year	No Charge (Deductible Waived)	50% Coinsurance after Deductible

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Prostate Cancer Screening PSA (Routine) - 1 per plan year	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Colon Cancer Screening (Routine) - age 45-75 Colonoscopy – 1 in 10 years Sigmoidoscopy – 1 in 3 years	No Charge (Deductible Waived)	50% Coinsurance after Deductible

Non-Preventive Medical Services			
All visit limitations shown in this Benefit Summary are combined In-Network and Out-of-Network limits.			
Benefit	**In-Network**		**Out-Of-Network**
Primary Care Physician Visits	**Professional Non-Facility based Services:** $35 Copay / per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Specialist Physician Visits	**Professional Non-Facility based Services:** $60 Copay / per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Maternity Professional Maternity Care for Dependent child is excluded.	**Professional Non-Facility based Services:** No Charge (Deductible Waived)	**Facility based Services:** No Charge (Deductible Waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Chiropractic Care – Limited to 30 visits per Calendar Year	$50 Copay / per visit		50% Coinsurance after Deductible
Non-Preventive Lab and Radiology			
Benefit	**In-Network**		**Out-Of-Network**
Lab and Pathology	**Office Setting or Independent Lab** $25 Copay / per visit (Deductible Waived)	**Facility based Services:** $50 Copay / per visit (Deductible Waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
X-Rays / Radiology	**Office Setting or Independent Lab** $50 Copay / per visit (Deductible Waived)	**Facility based Services:** $100 Copay / per visit (Deductible Waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
MRI / MRA; CT / CTA / PET Scan Genetic testing and counseling beyond ACA mandated is covered.	**Office Setting or Independent Lab** $100 Copay / per visit (Deductible Waived) *Savings Plus Plan Benefit*	**Facility based Services:** $200 Copay / per visit (Deductible Waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Sleep Studies/Sleep Management Services	**Office Setting or Independent Lab** $100 Copay / per visit (Deductible Waived) *Savings Plus Plan Benefit*	**Facility based Services:** $200 Copay / per visit (Deductible Waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Emergency Services			
Benefit	**In-Network & Out-Of-Network**		
Emergency Care	$500 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*		
Urgent Care	$75 Copay / per visit (Deductible waived) Out-of-Network Urgent Care Services covered as In-Network		
Emergency Medical Transportation: Ground, Air, and Water Ambulance are covered.	No Charge (Deductible waived) *Savings Plus Plan Benefit*		

Employee Benefit Summary – Advantage Savings Plus Plan
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Inpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Pre-Surgical / Pre-Admission Testing	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab Preauthorization is required Maternity – newborn under mother for well-baby; Maternity Care for Dependent child is excluded.	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Physician Services	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Maternity Professional	No Charge (Deductible Waived) *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Anesthesia	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Surgery- Surgeon/ Assistant Surgeon Charges	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Detoxification Preauthorization is required	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Physical Medical Rehab – Limited to 120 days per plan year. (Combined limit with Skilled Nursing Facility)	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Skilled Nursing Facility - Limited to 120 days per plan year. (Combined limit with physical medical rehab)	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Outpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Second Opinion – Surgical	**Professional Non-Facility based Services:** $35 Copay / per visit Non-Specialist $60 Copay / per visit Specialist	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Outpatient Surgery Facility Preauthorization is required.	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible

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Outpatient Surgery -Physician / Surgeon / Assistant Surgeon	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Anesthesia	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Home Health Care; Patient not required to be homebound. Home Health Aides are covered.	No Charge after Deductible		50% Coinsurance after Deductible
Hospice – Facility or Home	**Home Setting:** No Charge after Deductible	**Facility Setting:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Behavioral/Mental Health & Chemical / Substance or Alcohol Abuse: Medication Management, Psych testing, Eating disorders, Bereavement counseling, Partial Hospitalization, Intensive Outpatient Therapy, and Methadone clinics are covered. Halfway Homes are not covered.	**Professional Non-Facility based Services:** $35 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Therapy Services			
Benefit	**In-Network**		**Out-Of-Network**
ABA Therapy: Autism Spectrum disorder and Developmental delays are covered.	**Professional Non-Facility based Services:** $25 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Cardiac Rehabilitation	**Professional Non-Facility based Services:** $25 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Chemotherapy	**Professional Non-Facility based Services:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Dialysis / Hemodialysis Home Dialysis is covered	**All settings including Outpatient Facility, Office, and Home:** No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Gene/Cellular Therapy	Not Covered		Not Covered
Home Infusion	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Home visits – Professional	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Infusion Therapy	**Professional Non-Facility based Services:** $50 copay/per visit *Savings Plus Plan Benefit*	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Medical Nutrition Therapy	**Professional Non-Facility based Services:** No Charge (Deductible Waived)	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Occupational Therapy - Limited to 60 visits per plan year. Combined limit with Physical and Speech Therapy. Visit limits are followed with ASD diagnosis.	**Professional Non-Facility based Services:** **Visits 1-30:** $25 copay/per visit **Visits 31-60:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Orthoptic / Pleoptic Therapy Limited to 8, combined In-network and out-of-network, visits per lifetime	**Professional Non-Facility based Services:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Physical Therapy - Limited to 60 visits per plan year. Combined limit with Occupational and Speech Therapy. Visit limits are followed with ASD diagnosis.	**Professional Non-Facility based Services:** **Visits 1-30:** $25 copay/per visit **Visits 31-60:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Pulmonary/Respiratory Therapy	**Professional Non-Facility based Services:** $25 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Radiation Therapy	**Professional Non-Facility based Services:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Speech Therapy - Limited to 60 visits per plan year. Combined limit with Occupational and Physical Therapy. Visit limits are followed with ASD diagnosis.	**Professional Non-Facility based Services:** **Visits 1-30:** $25 copay/per visit **Visits 31-60:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Other Services			
Benefit	**In-Network**		**Out-Of-Network**
Abortion - Elective & Therapeutic Maternity Care for Dependent child is excluded.	**Professional Non-Facility based Services:** $35 copay/per visit (Deductible waived)	**Outpatient / Inpatient Facility:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Acupuncture	Not Covered		Not Covered
Allergy Services / Injections	**Professional Non-Facility based Services:** $50 copay/per visit	**Facility based Services:** 40% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Allergy Testing; subject to cost share shown, office visit copay/cost share is additional.	**Professional Non-Facility based Services:** No Charge after Deductible	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Alternative Medicine	Not Covered		Not Covered
Ambulance Service – Non Emergency Transport. Ground only	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Bariatric Surgery	Not Covered		Not Covered
Biofeedback	Not Covered		Not Covered
Blood Processing / Blood Storage Includes autologous donation	**Professional Non-Facility based Services:** No Charge after Deductible	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Dental – Accident to sound teeth only. Treatment must be started within 3 months of injury. Routine Dental is excluded. Dental Anesthesia for those 7 and under is covered.	**Professional Non-Facility based Services:** No Charge after Deductible	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

LEADING EDGE ADMINISTRATORS

Employee Benefit Summary – Advantage Savings Plus Plan
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Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. Breast Pumps are covered at 100%; Electric pumps – limited to 1 every 36 months; Manual pumps – limited to 1 every pregnancy	No Charge after Deductible		50% Coinsurance after Deductible
Foot Care (routine) – Diabetic only.	**Professional Non-Facility based Services:** $35 Copay / per visit Non-Specialist $60 Copay / per visit Specialist	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Gender Affirmation surgery	No Charge after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Hearing Aids (exams, fittings, and device)	Not Covered		Not Covered
Immunization (non-routine) Vaccinations for travel are excluded	No Charge		50% Coinsurance after Deductible
Infertility Services - Basic Testing Only; subject to cost share shown, office visit copay/cost share is additional.	**Professional Non-Facility based Services:** No Charge after Deductible	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF) Combined INN/OON with benefit limit of $2,000 per lifetime.	**Professional Non-Facility based Services:** No Charge after Deductible	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Injections	**Professional Non-Facility based Services:** $35 Copay / per visit Non-Specialist $60 Copay / per visit Specialist	**Facility based Services:** 40% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Medical Nutrition Products – PKU formulas and enteral feeding supplies	No Charge (Deductible Waived)		50% Coinsurance Deductible is waived
Medical Supplies Includes Ostomy supplies	No Charge after Deductible		50% Coinsurance after Deductible
Nutritional Counseling – Diabetic Limited to 6 visit per plan year.	**Professional Non-Facility based Services:** No Charge (Deductible Waived)	**Facility based Services:** No Charge (Deductible Waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Nutritional Counseling – Nondiabetics Limited to 6 visit per plan year.	**Professional Non-Facility based Services:** No Charge (Deductible Waived)	**Facility based Services:** No Charge (Deductible Waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Online visits - Telephone consultations are excluded	$35 Copay / per visit Non-Specialist $60 Copay / per visit Specialist		50% Coinsurance after Deductible
Oral Surgery – Includes removal of impacted wisdom teeth.	**Professional Non-Facility based Services:** No Charge after Deductible	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Orthotics and Prosthetic Devices – Diabetic shoes are covered	No Charge after Deductible		50% Coinsurance after Deductible
Private Duty Nursing – Limited to 360 hours per Calendar Year. Combined In and out of network hours.	No Charge after Deductible		50% Coinsurance after Deductible
Respite Care – Limited to 7 days every 6 months. 8 hours = 1 day	No Charge after Deductible		50% Coinsurance after Deductible
Retail Health Clinics	$10 Copay / per visit Deductible Waived		50% Coinsurance after Deductible
Sterilization – Men are covered. Woman are covered 100% per ACA.	**Professional Non-Facility based Services:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Sterilization Reversals– Men and woman are covered.	**Professional Non-Facility based Services:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
TMJ Treatment & Appliances	Not Covered		Not Covered
Vision Exams (Routine) and Hardware	Not Covered		Not Covered
Vision surgery – Cataract and Glaucoma (includes initial frames, lenses or contact following cataract surgery)	**Professional Non-Facility based Services:** $50 copay/per visit	**Facility based Services:** No Charge after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Wigs/Toupee – After Chemotherapy or Radiation Treatment	No Charge after Deductible		50% Coinsurance after Deductible

Transplant Services Centers of Excellence Locations Only		
Benefit	**In-Network**	**Out-Of-Network**
Live Donor Health Services	No Charge after Deductible	Not Covered
Bone Marrow Donor Search – Limited to $10,000 Per Calendar year	No Charge after Deductible	Not Covered
Organ Transplant – Facility	No Charge after Deductible	Not Covered
Organ Transplant – Physician & anesthesiologist	No Charge after Deductible	Not Covered
Travel and lodging for Organ Transplant	Maximum of $25,000 per Transplant	
Travel and lodging for Bone Marrow Donor Search	Maximum of $5,000 per Calendar Year	

Prescription Drug Benefits Carelon Rx 1-833-271-2374 www.carelonrx.com		
Generic (Tier 1)	**No cost for Preventive Rx Drugs** **30 day supply:** Lesser of cost of medication or $10.00 **Mail Order up to 90 day supply:** Lesser of cost of medication or $25.00	Not Covered
Preferred (Tier 2)	**30 day supply:** 35% of medication cost with $30 minimum $65 maximum **Mail Order up to 90 day supply:** 35% of medication cost with $65 minimum $125 maximum	Not Covered

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Non-Limited/Non-Preferred (Tier 3)	**30 day supply:** 50% of medication cost with $45 minimum $85 maximum **Mail Order up to 90 day supply:** 50% of medication cost with $90 minimum $160 maximum	Not Covered
Specialty (Tier 4)	Not Covered	Not Covered

Preauthorization (Leading Edge Administrators: 1-929-481-8128)

The following services require Preauthorization, or benefit will be reduced by $1,000 for inpatient stays or 20% for outpatient services.

**this list is subject to change at the discretion of the Utilization Manager, Leading Edge Administrators.*

Inpatient Services:	Outpatient Services:	Other Services:
Cervical Spine Surgery	Cartilage Transplant Knee	Bone Stimulator
Computer Navigation for Orthopedic Surgery	Cervical Spine Surgery	Cardio/External Defibrillator
Elective Admissions	Cochlear Implant	Cooling Devices
Emergency Admissions	Computer Navigation for Orthopedic Surgery	CPAP/BIPAP
Hospice	Lumbar Spine Surgery	Electric Scooters
Lumbar Spine Surgery	Mandibular/Maxillary Surgery (Orthognathic)	Infusion Pumps
Rehabilitation Facility Admissions	Mastectomy for Gynecomastia	Insulin Pumps
Sacroiliac Joint Fusion	Nasal Septoplasty	Limb Prosthetics
Skilled Nursing Facility Admissions	Reduction Mammoplasty	Myoelectric prosthetics
Transplants	Rhinoplasty	Neuromuscular Stimulators
	Sacroiliac Joint Fusion	TENS Unit
	Sclerotherapy (Lower Extremities)	Wheelchairs
Managed Care Services:	Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty	Wound Vacs
Inpatient BH/SA	Botulinum Toxin – Review for Migraine Use Only	Azacitidine (Vidaza)
Electric Convulsive Therapy (ECT)	Home Health Services	Bevacizumab (Avastin) – Review for Non-Eye Only
Intensive Outpatient Therapy	Home Hospice	Bortezomib (Velcade)
Partial Hospitalization (PHO)	Hyperbaric Oxygen Therapy (Systemic/Topical)	Etanercept (Enbrel)
Residential Care (RTC)	Coronary CT Angiography (CCTA)	Fulvestrant (Faslodex)
Psychological testing	Coronary MRA	Immune Globulin (Intravenous)
Genetic Counseling	Cardiac MRI	Infliximab (Remicade)
	MRA of the Head and/or Neck	Ipilimumab (Yervoy)
	MRI of the Brain	Nivolumab (Opdivo)
	MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral	Paclitaxel (Abraxane Only)
	PET Scan	Panitumubab (Vectibix)
	Physical/Occupational/Speech Therapy	Pembrolizumab (Keytruda)
		Pemetrexed (Alimta)

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		Rituximab (Rituxan) – Review for Non-Oncology Diagnosis/Treatment Only

Exclusions In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan	
Acupuncture	Long-Term Care
Alternative Medicine/homeopathy	Massage Therapy
Aquatic Therapy	Maternity Care for Dependent Child
Arch supports (supportive shoe inserts)	Non-Emergency Care outside the U.S.
Bariatric Surgery	Orthopedic Shoes/ orthopedic inserts
Biofeedback	Private Duty Nursing in a Hospice setting
Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy)	Routine Eye Care (Adult) and Child except ACA allowed
Custodial Care	Self-Inflicted unless result of medical condition
Dental Care (Routine) Adult and Child except ACA allowed	Specialty Medications (Rx and Medical)
Gene/Cellular Therapy	TMJ Treatment and Appliances
Growth Hormone Therapy	Vision Exam and Hardware
Halfway house/home – non-healthcare residential facility	Weight Loss Programs