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

Benefit	In-Network	Out-Of-Network
Plan Deductible	$3,500 Individual $7,000 Family	$4,500 Individual $12,000 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	30% - 40% Depending on Benefit	50%
Out of Pocket Maximum	$6,900 Individual $8,150 Individual in a family $13,800 Family	$13,800 Individual $16,300 Individual in a Family $27,600 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

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Pap-smear (Routine) – 1 per plan year	No Charge (Deductible Waived)	50% Coinsurance after Deductible
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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Specialist Physician Visits	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Maternity Professional Maternity Care for Dependent child is excluded.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Chiropractic Care – Limited to 30 visits per Calendar Year	30% Coinsurance after Deductible		50% Coinsurance after Deductible

Non-Preventive Lab and Radiology			
Benefit	**In-Network**		**Out-Of-Network**
Lab and Pathology	**Office Setting or Independent Lab:** 30% Coinsurance after Deductible	**Facility based Services:** 40% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
X-Rays / Radiology	**Office Setting or Independent Lab:** 30% Coinsurance after Deductible	**Facility based Services:** 40% Coinsurance after Deductible *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:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	**Facility based Services:** 40% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Sleep Studies/Sleep Management Services	**Office Setting, Home, or Independent Lab:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	**Facility based Services:** 40% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Emergency Services			
Benefit	**In-Network & Out-Of-Network**		
Emergency Care	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		
Urgent Care	30% Coinsurance after Deductible Out-of-Network Urgent Care Services covered as In-Network		
Emergency Medical Transportation: Ground, Air, and Water Ambulance are covered.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		
Inpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Pre-Surgical / Pre-Admission Testing	30% Coinsurance 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.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Physician Services	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Maternity Professional	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Anesthesia	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Surgery- Surgeon/ Assistant Surgeon Charges	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Detoxification Preauthorization is required	30% Coinsurance 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)	30% Coinsurance 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)	30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Outpatient Surgery Facility Preauthorization is required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Outpatient Surgery -Physician / Surgeon / Assistant Surgeon	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Anesthesia	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Home Health Care; Patient not required to be homebound. Home Health Aides are covered.	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Hospice – Facility or Home	**Home Setting:** 30% Coinsurance after Deductible	**Facility Setting:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Cardiac Rehabilitation	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Chemotherapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Dialysis / Hemodialysis Home Dialysis is covered	**All settings including Outpatient Facility, Office, and Home** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Gene/Cellular Therapy	Not Covered		Not Covered
Home Infusion	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Home visits – Professional	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Infusion Therapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Medical Nutrition Therapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Orthoptic / Pleoptic Therapy Limited to 8, combined In-network and out-of-network, visits per lifetime	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Pulmonary/Respiratory Therapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Radiation Therapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Outpatient / Inpatient Facility:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Acupuncture	Not Covered		Not Covered
Allergy Services / Injections	**Professional Non-Facility based Services:** 40% Coinsurance after Deductible	**Facility based Services:** 40% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Allergy Testing; subject to cost share shown, office visit copay/cost share is additional.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Alternative Medicine	Not Covered		Not Covered
Ambulance Service – Non Emergency Transport. Ground only	30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
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	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Foot Care (routine) – Diabetic only.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Gender Affirmation surgery	30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Outpatient Facility Setting:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

LEADING EDGE ADMINISTRATORS

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Injections	**Professional Non-Facility based Services:** 40% Coinsurance after Deductible	**Facility based Services:** 40% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Medical Nutrition Products – PKU formulas and enteral feeding supplies	30% coinsurance Deductible is Waived		50% Coinsurance Deductible is waived
Medical Supplies Includes Ostomy supplies	30% Coinsurance 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	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Oral Surgery – Includes removal of impacted wisdom teeth.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Orthotics and Prosthetic Devices – Diabetic shoes are covered	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Private Duty Nursing – Limited to 360 hours per Calendar Year. Combined In and out of network hours.	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Respite Care – Limited to 7 days every 6 months. 8 hours = 1 day	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Retail Health Clinics	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Sterilization – Men are covered. Woman are covered 100% per ACA.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Sterilization Reversals– Men and woman are covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance 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:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Wigs/Toupee – After Chemotherapy or Radiation Treatment	30% Coinsurance after Deductible		50% Coinsurance after Deductible

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Transplant Services Centers of Excellence Locations Only		
Benefit	**In-Network**	**Out-Of-Network**
Live Donor Health Services	30% Coinsurance after Deductible	Not Covered
Bone Marrow Donor Search – Limited to $10,000 Per Calendar year	30% Coinsurance after Deductible	Not Covered
Organ Transplant – Facility	30% Coinsurance after Deductible	Not Covered
Organ Transplant – Physician & anesthesiologist	30% Coinsurance 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**		
Copayments and Cost Shares listed apply after plan deductible has been met.		
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
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

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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)
		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