

MEDICAL PLANS

Medical Plan Options	Pro	Max
Evidence of insurability	Guaranteed Acceptance	
PPO Network⁷	First Health[®]	
Deductible Individual/ Family	\$0	\$2,000/\$4,000
Out-of-Pocket Max Individual/ Family	\$9,200/\$18,400	\$9,200/\$18,400
Medical Services	In-Network Provider (No Out of Network Coverage)	
Preventive & Wellness Services (Non-Hospital Based)	\$0 Copay (Plan pays 100% of covered preventive and wellness services)	
Primary Care Office Visit (Non-Hospital Based)	\$25 Copay (Combined visit of 5 visits/plan yr)	\$25 Copay
Specialist Office Visit (Non-Hospital Based)		\$50 Copay
Urgent Care (Non-Hospital Based)		
Telemedicine Services	\$0 Copay ⁶	
Outpatient Diagnostic Services		
Laboratory Services (Non-Hospital Based)	\$25 Copay (Combined limit of 5 visits/plan yr)	\$50 Copay per panel tested or image billed
Radiology (Non-Hospital Based)		
CT/MRI/PET Scan (Non-Hospital Based)	Not Covered	50% Coinsurance (after Deductible) ⁴
Hospitalization and Emergency Services		
Inpatient Hospitalization ²	Not Covered	
Inpatient Surgery ²		
Outpatient Hospital or Free Standing Facility Services and Surgery ²		
Emergency Room Services ²		
Anesthesia ²		
Pregnancy Benefits		
Office Visits	\$25 Copay (Considered a Specialist Office Visit)	\$50 Copay (Considered a Specialist Office Visit)
Professional Services	Not Covered	
Maternity/Childbirth/Delivery ²		
Mental Health, Behavioral Health, or Substance Abuse Services		
Inpatient or Partial Day ²	Not Covered	
Outpatient Hospital or Free-Standing Facility ²		
Office Visits	\$25 Copay (Max 5 Visits/plan yr; Combined 5 Visit/plan yr)	\$25 Copay/visit ⁵
Other Services		
Rehabilitation/Habilitation Services (Physical, Speech, and Occupational)	Not Covered	\$50 Copay/visit (Combined limit of 20 visits/plan yr.) (Pre-Authorization is required after 6 visits.)
Allergy Services ³		
Emergency Medical Transportation ²		
Home Health Care		
Second Surgical Opinion		
Chiropractic Services		
Hospice Care ²		
Prosthetic and Orthotic devices ²		
Skilled Nursing Facility ²		
Durable Medical Equipment ²		
PHARMACY BENEFITS - Included in Medical Plans		
Preventive Prescriptions	No Copay for ACA Compliant covered prescription drugs	
Non-Preventive Prescriptions	20% Coinsurance - Generic Only 12 Prescriptions Maximum 30 day supply Maximum	\$20 Copay - Generic only 30 day supply Maximum
PHARMACY BENEFITS - Provided by DataRX⁵		
Prescription Benefit	Not Covered	Copay: \$10 Formulary Generic; \$50 Formulary Brand Mail Copay: \$30 Formulary Generic; \$150 Formulary Brand Annual Max: \$750 Per Person; \$1500 Per Family
Monthly Rates	Pro	Max
Individual	\$167.40	\$250.92
Individual + Spouse	\$249.91	\$420.84
Individual + Child	\$240.20	\$429.26
Family	\$320.48	\$635.31

Not available in Alaska, Hawaii, Massachusetts, and New Hampshire.

1. Combined 5 visits per year; Primary Care Visit to Treat Injury or Illness, Specialist, and Urgent Care Visits.
2. Subject to Reference Based Pricing
3. Included in Primary Care or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit
4. Pre-authorization required.
5. Prescription Benefit is offered through AC&A Limited Partnership by DataRx and is not integrated with the health plan design. The prescription provided by DataRx is not available in NY, SD, and WA. For the Max plan only: In the states noted, \$20 co-pay generic only, 30 day supply max.

6. This benefit is offered through AC&A LP by a third party and is not integrated with the health plan design.
7. First Health Provider look-up: <http://www.firsthealthlbp.com/>
Reference the Summary Plan Document for a list of services offered In-Network and Out-of-Network. Refer to the Schedule of Benefits for a more in-depth list of benefits coverage, limitations and exclusions. If this document differs from the Schedule of Benefits, the Schedule of Benefits will govern.
This coverage is available when you join the Limited Partnership. Partners must be active to maintain eligibility.

LP: Pro, Max, Value, & Bronze Pro Plans 10-1-25 01