

MEDICAL PLANS

Medical Plan Options	Value	Bronze Pro	
Evidence of insurability	Guaranteed Acceptance		
PPO Network^{6,7}	MultiPlan [®] : PHCS; Practitioner & Ancillary		
Deductible Individual/ Family	\$0	\$5,000/\$10,000	
Out-of-Pocket Max Individual/ Family	\$9,200/\$18,400	\$9,200/\$18,400	
Medical Services	In-Network Provider		
Preventive & Wellness Services (Non-Hospital Based)	\$0 Copay (Plan pays 100% of covered preventive and wellness services)		
Primary Care Office Visit (Non-Hospital Based)	\$60 Copay (Max 6 visits/plan yr)	\$25 Copay	
Specialist Office Visit (Non-Hospital Based)		\$45 Copay	
Urgent Care (Non-Hospital Based)	\$50 Copay (Max 6 visits/plan yr)	\$60 Copay	
Telemedicine Services	\$0 Copay ⁵		
Outpatient Diagnostic Services			
Laboratory Services (Non-Hospital Based)	\$50 Copay (Combined 3 visits /plan yr)	After Deductible, 20% coinsurance	
Radiology (Non-Hospital Based)			
CT/MRI/PET Scan (Non-Hospital Based)	\$350 Copay ^{1,3} (Max of 1/plan yr)	After Deductible, 20% coinsurance ^{1,3}	
Hospitalization and Emergency Services			
Inpatient Hospitalization ¹	\$350 Copay per admission ^{1,3} (Max 3 days/plan yr)	After Deductible, 20% coinsurance ³	
Inpatient Surgery ¹	Included in Inpatient Hospitalization Copay ^{1,3} (Second surgical opinion may be required; Max 2 surgeries/plan yr)		
Outpatient Hospital or Free Standing Facility Services and Surgery ¹	\$350 Copay ³ (Max 1 visit/plan yr)		
Emergency Room Services ¹	\$350 Copay (Max 1 visit/plan yr)	After Deductible, 20% coinsurance	
Anesthesia ¹	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay (Limited to 2 inpatient and 1 outpatient anesthetic procedures/plan yr)	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Benefit	
Pregnancy Benefits			
Office Visits	Not Covered	\$25 Copay /visit	
Professional Services			
Maternity/Childbirth/Delivery ¹		After Deductible, 20% coinsurance ³	
Mental Health, Behavioral Health, or Substance Abuse Services			
Inpatient or Partial Day ¹	\$350 Copay per admission (Limited to 3 days/plan yr)	After Deductible, 20% coinsurance ³	
Outpatient Hospital or Free-Standing Facility ¹	\$350 Copay (Limited to 1 visit/plan yr)	After Deductible, 20% coinsurance	
Office Visits	\$60 Copay (Limited to 6 visits/plan yr)	\$45 Copay	
Other Services			
Rehabilitation/Habilitation Services (Physical, Speech, and Occupational)	\$50 Copay (Combined max 6 days/plan yr with physical, speech, & occupational therapies)	\$45 Copay /visit ³ (Combined limit to 20 visits/plan yr. Pre-authorization is required after 6 visits.)	
Allergy Services	\$25 Copay ²	After Deductible, 20% coinsurance (Max 20 visits/plan yr)	
Emergency Medical Transportation ¹	\$250 Copay (By land only; Max 1 transport/plan yr)	After Deductible, 20% coinsurance	
Home Health Care	\$25 Copay ³ (Max 5 visits/plan yr)	After Deductible, 20% coinsurance ³ (Max 60 visits/plan yr)	
Second Surgical Opinion	\$0 Copay	\$0 Copay ³	
Chiropractic Services	Not Covered	\$45 Copay/visit (Limited to 20 visits/plan yr)	
Hospice Care ¹		After Deductible, 20% coinsurance ³	
Prosthetic and Orthotic devices ¹		After Deductible, 20% coinsurance (Max of \$6,500/plan yr)	
Skilled Nursing Facility ¹		After Deductible, 20% coinsurance ³ (Max 60 visits/plan yr)	
Durable Medical Equipment ¹		After Deductible, 20% coinsurance (Subject to limitations)	
PHARMACY BENEFITS - Included in Medical Plans			
Preventive Prescriptions		No Copay for ACA Compliant covered prescription drugs	
Non-Preventive Prescriptions	Generic - \$10 Copay	\$10 Copay - Generic only \$45 Copay- Preferred Brand \$100 Copay- Non-Preferred Brand	
PHARMACY BENEFITS - Provided by DataRx⁴			
Prescription Benefit	Copay: \$10 Formulary Generic; \$50 Formulary Brand Mail Copay: \$30 Formulary Generic; \$150 Formulary Brand Annual Max: \$750 Per Person; \$1500 Per Family	Not Covered	
Monthly Rates	Value	Bronze Pro	
Individual	\$537.12	\$615.60	
Individual + Spouse	\$1,046.15	\$1,214.17	
Individual + Child	\$917.98	\$1,076.68	
Family	\$1,403.66	\$1,656.27	

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

- Subject to Reference Based Pricing
- 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
- Pre-authorization required.
- 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.
- This benefit is offered through AC&A LP by a third party and is not integrated with the health plan design.

6. First Health Provider look-up: <http://www.firsthealthlp.com/>

7. Multiplan PHCS Practitioner and Ancillary provider search: <https://www.multiplan.com/webcenter/portal/ProviderSearch>

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

MEDICAL PLANS

Preventive Health Services: Limitations, Intervals, and Requirements¹

The following table represents the preventive services currently covered under the Pro, Max, Value, Bronze Plans as well as the permitted interval and any requirements of such preventive services.

Benefits are automatically subject to 29 CFR § 2590.715 -2713(a). Amendments to this section through legislative act or regulation are automatically incorporated into this document by reference. Preventive Services covered in this section are explained in more detail through the following official resources:

- Medical services with a rating of "A" or "B" from the current recommendations of the United States Preventive Services Task Force. See <https://www.uspreventiveservicestaskforce.org>
- Preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Guidelines can be found in <https://www.hrsa.gov>
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for certain individuals only. See <https://www.cdc.gov/vaccines/acip>

Preventative and Wellness Services - Covered Benefits

<p>Adults</p> <ul style="list-style-type: none"> • Adult Annual Standard Physical • Alcohol Misuse: Unhealthy Alcohol Use Screening and Counseling • Aspirin: Preventive Medication • Blood pressure screening • Breastfeeding interventions • Chlamydia screening • Colorectal Cancer Screening • Dental cavities prevention: infants and children up to age 5 years • Depression Screening • Diabetes Screening • Fall Prevention: Older Adults • Healthy Diet and Physical Activity Counseling to Prevent Cardiovascular Disease • Hemoglobinopathies screening • Hepatitis B screening • Hepatitis C virus (HCV) infection screening: born between 1945 and 1965. • High Blood Pressure Screening • HIV Preexposure Prophylaxis for the Prevention of HIV Infection • HIV Screening • Hypothyroidism screening • Lung Cancer Screening • Obesity screening and Counseling • Sexually Transmitted Infections Counseling • Skin Cancer Behavioral Counseling • Statin Preventive Medication • Tobacco Use Counseling and Interventions • Syphilis Screening 	<p>Men</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening <p>Women</p> <ul style="list-style-type: none"> • Aspirin: Preventive Medication • BRCA risk assessment and genetic counseling/testing • Breast Cancer Preventive Medications • Breast Cancer Screening • Cervical Cancer Screening: with Cytology (Pap Smear) Lung cancer screening • Chlamydia Screening • Contraceptive Methods and Counseling • Folic Acid Supplementation • Gonorrhea Screening • Intimate Partner Violence Screening • Osteoporosis Screening • Well-Woman Visits <p>Pregnant Women</p> <ul style="list-style-type: none"> • Bacteriuria Screening • Breastfeeding Support, Supplies and Counseling • Depression Screening • Gestational Diabetes Mellitus Screening • Hepatitis B Screening • HIV Screening • Preeclampsia Screening • Rh Incompatibility Screening: First Pregnancy Visit • RH Incompatibility Screening: 24–28 Weeks' Gestation • Syphilis Screening • Tobacco Use Counseling and Interventions 	<p>Newborns</p> <ul style="list-style-type: none"> • Gonorrhea Prophylactic Medication • Hemoglobinopathies Screening • Hypothyroidism Screening • Phenylketonuria Screening <p>Infants</p> <ul style="list-style-type: none"> • Dental Caries Prevention: Infants and Children Up to Age 5 <p>Children</p> <ul style="list-style-type: none"> • Dental Caries Prevention: Infants and Children Up to Age 5 • Obesity screening and Counseling • Skin Cancer Behavioral Counseling • Tobacco Use Counseling and Interventions • Vision Screening: Age 3 to 5 • Well-Child Visits <p>Adolescents</p> <ul style="list-style-type: none"> • Depression Screening • Hepatitis B Screening • HIV Screening • Obesity screening and Counseling • Sexually Transmitted Infections Counseling • Skin Cancer Behavioral Counseling • Tobacco Use Counseling and Interventions <p>Multiple Populations</p> <ul style="list-style-type: none"> • Tuberculosis Screening: all populations at risk • Skin Cancer Behavioral Counseling: young adults, adolescents, children, and parents of young children
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*See Schedule of Benefits for Limitations, Intervals and Requirements.

Vaccines

IMMUNIZATIONS - recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for routine use in children, adolescents, or adults*

Adults 19 Years or Older	Children From 7 Through 18 Years Old	Birth Through 6 Years Old		
<ul style="list-style-type: none"> • IIV • RIV • LAIV • Tdap • MMR • VAR • RZV • ZVL • HPV - Female • HPV- Male • PCV13 • PPSV23 	<ul style="list-style-type: none"> • Flu • Tdap • HPV • MenACWY • MenACWY 	<ul style="list-style-type: none"> • HepB • DTaP • Hib • PCV13 	<ul style="list-style-type: none"> • IPV • Flu • MMR 	<ul style="list-style-type: none"> • VAR • HepA • RV

1. None of the Preventive Health Services are covered if they are provided at a hospital.

* Immunization illustrations listed herein are based upon CDC recommendations contained in the following schedules: (i) Recommended Child and Adolescent Immunization Schedule (available at: <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>), and (ii) Recommended Adult Immunization Schedule (available at: <https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html>). Additional immunization scenarios not included in the aforementioned illustrations (such as catch-up immunization recommendations, immunization recommendations for certain high-risk groups, and immunization recommendations subject to individual clinical decision-making) may also be covered under this Plan pursuant to CDC recommendation. Information concerning these additional covered immunization scenarios (including vaccine type, age requirements, and frequency) is available online under the CDC schedule links listed above. Paper copies of these CDC schedules can also be obtained free of charge by written request to the Plan Administrator.

This plan is ACA Compliant. For additional information, visit: <https://www.healthcare.gov/coverage/preventive-care-benefits/> as benefits are subject to change. Or reference the Summary Plan Document for a list of Wellness & Preventative services offered In-Network.



On your coverage effective date, you will gain access to the Rolling Strong wellness application to manage your own personal health goals, your health plans, and access to your ID Cards and provider network.