

# LGI Services LLC 1500 PPO



Plan: 0044669-01 | Effective: 2027-01-01T00:00:00 | Parent ID: 00017125  
 Health | Traditional | Traditional Single/Family - Single copay  
 PPO | Alliance Select - Standard  
 Self Funded | ERISA  
 Deductible: Yes | OPM: Yes

| Cost Shares - In Network |                |                 |           |         |            |             |
|--------------------------|----------------|-----------------|-----------|---------|------------|-------------|
| Cost Share Level         | Emergency Room | Independent Lab | Inpatient | Office  | Outpatient | Urgent Care |
| Copay                    | n/a            | n/a             | n/a       | n/a     | n/a        | n/a         |
| Coinsurance              | 20 %           | 20 %            | 20 %      | 20 %    | 20 %       | 20 %        |
| Deductible - Single      | \$1,500        | n/a             | \$1,500   | n/a     | \$1,500    | n/a         |
| Deductible - Family      | \$3,000        | n/a             | \$3,000   | n/a     | \$3,000    | n/a         |
| Out of Pocket - Single   | \$3,200        | \$3,200         | \$3,200   | \$3,200 | \$3,200    | \$3,200     |
| Out of Pocket - Family   | \$6,400        | \$6,400         | \$6,400   | \$6,400 | \$6,400    | \$6,400     |

| Cost Shares - Out of Network |                |                 |           |          |            |             |
|------------------------------|----------------|-----------------|-----------|----------|------------|-------------|
| Cost Share Level             | Emergency Room | Independent Lab | Inpatient | Office   | Outpatient | Urgent Care |
| Copay                        | n/a            | n/a             | n/a       | n/a      | n/a        | n/a         |
| Coinsurance                  | 20 %           | 30 %            | 30 %      | 30 %     | 30 %       | 30 %        |
| Deductible - Single          | \$1,500        | \$2,000         | \$2,000   | \$2,000  | \$2,000    | \$2,000     |
| Deductible - Family          | \$3,000        | \$4,000         | \$4,000   | \$4,000  | \$4,000    | \$4,000     |
| Out of Pocket - Single       | \$3,200        | \$6,000         | \$6,000   | \$6,000  | \$6,000    | \$6,000     |
| Out of Pocket - Family       | \$6,400        | \$12,000        | \$12,000  | \$12,000 | \$12,000   | \$12,000    |

| Benefit Specific Office Cost Share - In Network |                |                     |                     |             |              |              |
|-------------------------------------------------|----------------|---------------------|---------------------|-------------|--------------|--------------|
| Benefit Group                                   | Copay (Office) | Deductible - Single | Deductible - Family | Coinsurance | OPM - Single | OPM - Family |
| Telehealth (Vendored)                           | \$20           | n/a                 | n/a                 | n/a         | \$3,200      | \$6,400      |
| Telehealth (Non Vendored)                       | n/a            | n/a                 | n/a                 | 20 %        | \$3,200      | \$6,400      |
| Chiropractic                                    | n/a            | n/a                 | n/a                 | 20 %        | \$3,200      | \$6,400      |
| Physical Therapy                                | n/a            | n/a                 | n/a                 | 20 %        | \$3,200      | \$6,400      |
| Occupational Therapy                            | n/a            | n/a                 | n/a                 | 20 %        | \$3,200      | \$6,400      |
| Speech Therapy                                  | n/a            | n/a                 | n/a                 | 20 %        | \$3,200      | \$6,400      |

**Benefit Specific Office Cost Share - In Network (Continued)**

| Benefit Group         | Copay (Office) | Deductible - Single | Deductible - Family | Coinsurance | OPM - Single | OPM - Family |
|-----------------------|----------------|---------------------|---------------------|-------------|--------------|--------------|
| Vision Exam - Routine | n/a            | n/a                 | n/a                 | n/a         | n/a          | n/a          |

**BENEFITS**

| Benefit Group                       | Benefit Description                                                                                                                                                                                   |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ABA Therapy                         | ABA Therapy is covered.                                                                                                                                                                               |
| Accident Care                       | Accidental injury services are covered.                                                                                                                                                               |
| Bariatric Surgery                   | Bariatric surgery is covered.                                                                                                                                                                         |
| BDC - Bariatric Surgery             | Facility services for bariatric surgery are not limited to Blue Distinction Centers.                                                                                                                  |
| BDC - Cancer Care                   | Facility services for Cancer Care are not limited to Blue Distinction Centers.                                                                                                                        |
| BDC - Cardiac Care                  | Facility services for Cardiac Care are not limited to Blue Distinction Centers.                                                                                                                       |
| BDC - Fertility Care                | Provider services for Fertility Care are not limited to Blue Distinction Centers.                                                                                                                     |
| BDC - Knee and Hip Replacement      | Facility services for knee and hip replacement are not limited to Blue Distinction Centers.                                                                                                           |
| BDC - Spine Surgery                 | Facility services for spine surgery are not limited to Blue Distinction Centers.                                                                                                                      |
| BDC - Transplant                    | Facility services for transplant surgery are not limited to Blue Distinction Centers.                                                                                                                 |
| Chiropractic                        | Chiropractic services are covered.                                                                                                                                                                    |
| Dental Accidental Injury            | Dental treatment for accidental injury (excluding acts of chewing) is covered if initiated within 12 months of accident and completed within 24 months.                                               |
| Facility Skilled Nursing - Facility | Facility based skilled nursing services are covered.                                                                                                                                                  |
| Hearing Aids                        | Hearing aids are not covered by the plan.                                                                                                                                                             |
| Hospice Respite                     | Hospice Respite care is covered to a lifetime maximum of 15 days inpatient and 15 days outpatient (limits are separate).                                                                              |
| Independent Lab                     | Independent Lab is covered.                                                                                                                                                                           |
| Infertility                         | Infertility services and prescription drugs for infertility are covered. Artificial insemination, IVF, GIFT, ZIFT, and other transfer procedures are limited to the following per lifetime: \$15,000. |
| Specialty Medical Drugs             | Most specialty drugs are covered under the Prescription Drug Program.                                                                                                                                 |
| Surgical Removal of Impacted Teeth  | Surgical removal of impacted teeth is covered when there is a concurrent medical condition.                                                                                                           |
| Telehealth (Vendored)               | Telehealth services (Vendored) are covered for medical and mental health/chemical dependency.                                                                                                         |
| Temporomandibular Joint Disorder    | Temporomandibular Joint Disorder treatment is covered, except for routine dental services, dental restorations/extractions, and orthodontic treatment.                                                |
| Vision Exam - Routine               | Routine vision exams are not covered.                                                                                                                                                                 |

**OTHER BENEFITS**

| Benefit Group      | Benefit Description                                        | Status     |
|--------------------|------------------------------------------------------------|------------|
| Gender Affirmation | Gender Affirmation services and treatment are not covered. | Customized |

| OTHER BENEFITS (Continued) |                                                                                                                                                                                                       |             |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| Benefit Group              | Benefit Description                                                                                                                                                                                   | Status      |
| Lab Expansion              | Preventive labs expanded to cover blood glucose testing, lipid panels, excluding A1C tests, regardless of age, when billed as part of a routine physical or screening for diabetes.                   | Customized  |
| Retail Drug Coverage       | Retail drugs are covered under freestanding coverage under Pharmacy Benefit Manager (PBM) CVS.                                                                                                        | Customized  |
| ACA - Mammogram Screening  | Mammography screenings are covered unlimited.                                                                                                                                                         | Alternative |
| Infertility                | Infertility services and prescription drugs for infertility are covered. Artificial insemination, IVF, GIFT, ZIFT, and other transfer procedures are limited to the following per lifetime: \$15,000. | Alternative |
| Vision Exam - Routine      | Routine vision exams are not covered.                                                                                                                                                                 | Alternative |

| FEATURES                                                       |                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Feature Description                                            | Feature Trait Description                                                                                                                                                                                                                           |
| Deductible aggregation between PPO and non-PPO                 | Tiered deductible amounts are aggregate (both ways) - PPO and Non-PPO deductibles apply to each other.                                                                                                                                              |
| Deductible Embedded or non-Embedded                            | Member has benefits after single deductible met. Entire family has benefits after family or two-person deductible has been met.                                                                                                                     |
| Office visit coinsurance following copay                       | Coinsurance does not follow office visit copay.                                                                                                                                                                                                     |
| Office visit copay applies to                                  | Office visit copay applies to any office service.                                                                                                                                                                                                   |
| Office visit copay applies to out of pocket maximum            | Office visit copay applies to the out of pocket maximum and does not continue after the out of pocket maximum is met.                                                                                                                               |
| Office visit copay applies to services received from           | Office visit copay applies to services received from PPO practitioners.                                                                                                                                                                             |
| Office visit copay includes                                    | Office visit copay includes telehealth services provided by a physician's office.                                                                                                                                                                   |
| Office visit copay is taken                                    | Office visit copay is taken per practitioner per date of service.                                                                                                                                                                                   |
| Office visit deductible following copay                        | Deductible does not follow office visit copay.                                                                                                                                                                                                      |
| Out of Pocket Maximum aggregation between Health and Pharmacy  | Out of Pocket Maximums do not aggregate both ways between Health and Pharmacy.                                                                                                                                                                      |
| Out of Pocket Maximum aggregation between PPO and non-PPO      | Tiered out of pocket maximum amounts are aggregate (both ways). PPO and non-PPO out of pocket amounts apply to each other.                                                                                                                          |
| Out of Pocket Maximum credit for Wellmark to Wellmark transfer | Out of Pocket Maximum credit for Wellmark to Wellmark transfer allows carryover from a previous employer group to this employer group.                                                                                                              |
| Out of Pocket Maximum Embedded or non-Embedded                 | Member has benefits after single out of pocket maximum has been met. Entire family has benefits after family or two-person out of pocket maximum has been met.                                                                                      |
| Primary Care Practitioner Definition                           | Primary Care Practitioner (PCP) is defined as General Practice, Family Practice, Internal Medicine, Obstetrics/gynecology, Pediatricians, Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants. All other providers are Non-PCP. |
| Prior commercial credit                                        | Prior commercial credit is not applicable.                                                                                                                                                                                                          |

| FEATURES (Continued)         |                                         |
|------------------------------|-----------------------------------------|
| Feature Description          | Feature Trait Description               |
| Prior commercial credit from | prior commercial credit not applicable. |

| OTHER FEATURES                                                        |                                                                                                                            |             |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------|
| Feature Description                                                   | Feature Trait Description                                                                                                  | Status      |
| Deductible aggregation between PPO and non-PPO                        | Tiered deductible amounts are aggregate (both ways) - PPO and Non-PPO deductibles apply to each other.                     | Customized  |
| Out of Pocket Maximum aggregation between PPO and non-PPO             | Tiered out of pocket maximum amounts are aggregate (both ways). PPO and non-PPO out of pocket amounts apply to each other. | Customized  |
| Deductible aggregation between Health and Pharmacy                    | Deductibles do not aggregate between Health and Pharmacy.                                                                  | Alternative |
| Inpatient facility coinsurance following copay                        | Coinsurance follows inpatient facility copay.                                                                              | Alternative |
| Inpatient facility copay applies to services received from            | Inpatient facility copay applies to services received from all providers.                                                  | Alternative |
| Inpatient facility copay maximum number per person per benefit period | Inpatient facility copay is not limited to a maximum number per person per benefit period.                                 | Alternative |
| Out of Pocket Maximum aggregation between Health and Pharmacy         | Out of Pocket Maximums do not aggregate both ways between Health and Pharmacy.                                             | Alternative |

# LGI Services LLC CARVEOUT RX



Plan: 0044668-01 | Effective: 2027-01-01T00:00:00 | Parent ID: 00017125  
Pharmacy | Not Applicable | Carved Out - Freestanding Coverage  
Pharmacy - Not Applicable | Carved Out - Freestanding Coverage  
Self Funded | ERISA  
Deductible: N/A | OPM: N/A