LEADING EDGE ADMINISTRATORS

Wall Street Holding Group Inc. DBA Arch Telecom Inc
Employee Benefit Summary - Bronze
Network: National PPO (BlueCard PPO) Network
Effective Date: 01/01/2026

Benefit	In-Network	Out-Of-Network
Plan Deductible	Individual: $6,000 Family: $12,000	Individual: $6,000 Family: $12,000
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%	50%
Out of Pocket Maximum	$6,000 Individual $12,000 Family	$6,000 Individual $12,000 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.

Prescription Drug Benefits
Carelon Rx 1-833-267-2133 www.carelonrx.com

Generic (Tier 1)	No Copay for Preventive Drugs Retail : $20 copay per prescription 90 day Mail Order : $40 copay per prescription	Not Covered
Brand (Tier 2)	Retail : $60 copay per prescription 90 day Mail Order : $120 copay per prescription	Not Covered
Non-Preferred (Tier 3)	Retail : $90 copay per prescription 90 day Mail Order : $180 copay per prescription	Not Covered
Specialty (Tier 4)	Retail : $90 copay per prescription 90 day Mail Order : N/A	Out-Of-Network: Not Covered

Preventive Medical Services

Benefit	In-Network	Out-Of-Network
Primary Care Physician Office: Adult Routine Physical - 1 visit per calendar year.	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Pediatrician - Well Child Care: Up to age 2 - 9 visits per calendar year Age 2 – 2 visits per calendar year Age 3 and more – 1 visit per calendar year	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Children Eye Exam	No Charge (Deductible Waived)	50% Coinsurance after Deductible

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Gynecological - Adult Routine Physical - 1 visit per calendar 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 calendar year; Age 40 and more	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Pap-smear (Routine) – 1 per calendar year	No Charge (Deductible Waived)	50% Coinsurance after Deductible
Prostate Cancer Screening PSA (Routine) - 1 per calendar 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

Benefit	In-Network		Out-Of-Network
Primary Care Physician Visits	**Professional Non-Facility based Services:** No Charge (Deductible waived)	**Facility based Services:** No Charge (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Specialist Physician Visits	**Professional Non-Facility based Services:** $50 Copay / per visit (Deductible waived)	**Facility based Services:** $50 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Maternity Professional – Maternity care for a dependent child is covered.	**Professional Non-Facility based Services:** No Charge (Deductible waived)	**Facility based Services:** No Charge (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

Non-Preventive Lab and Radiology

Benefit	In-Network		Out-Of-Network
Lab and Pathology	**Office Setting or Independent Lab:** No Charge (Deductible waived)	**Facility based Services:** No Charge (Deductible waived) *Savings Plus Plan Benefit*	No Charge (Deductible waived)
X-Rays / Radiology	**Office Setting or Independent Lab:** No Charge (Deductible waived)	**Facility based Services:** No Charge (Deductible waived) *Savings Plus Plan Benefit*	No Charge (Deductible waived)
MRI / MRA; CT / CTA / PET Scan; Genetic testing and counseling beyond ACA mandated is not covered.	**Office Setting or Independent Lab:** $300 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*	**Facility based Services:** $300 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Sleep Studies/Sleep Management Services	Not Covered		
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 .	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 - Dependent Children are covered.	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. Methadone Clinics are Not Covered.	30% coinsurance after deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Detoxification Methadone Clinics are Not Covered.	30% coinsurance after deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Inpatient Physical Medical Rehab - Limited to 60 days per calendar year combined with skilled nursing.	30% coinsurance after deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Skilled Nursing Facility - Limited to 60 days per calendar year combined with IP medical rehab. Precertification Required.	30% coinsurance after deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Outpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Outpatient Surgery Facility- Preauthorization is required for certain services.	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
Second Opinion – Surgical	**Professional Non-Facility based Services:** No Charge (Deductible waived)	**Facility based Services:** No Charge (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Home Health Care - Patient required to be homebound. Home Health Aides are covered. Limited to 100 visits per calendar year.	30% coinsurance after deductible		50% Coinsurance after Deductible
Home visits – (Professional)	Not Covered		
Hospice – Facility and/or Home. Precertification Required. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 18 months or less.	**All Settings:** 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 and Bereavement counseling are covered. Partial Hospitalization and Intensive Outpatient Therapy are covered. Methadone clinics and Halfway Homes are not covered.	**Professional Non-Facility based Services:** No Charge (Deductible waived)	**Facility based Services:** No Charge (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Therapy Services			
Benefit	**In-Network**		**Out-Of-Network**
ABA Therapy: Autism Spectrum disorder covered. 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 - Phases I and II are covered. Precertification required for certain services.	**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 - Limited to $1,500 per date of service. Precertification required for certain services.	**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, Combined Institutional /Professional. Combined In and Out of Network	**Professional Non-Facility based Services:** $50 Copay / per visit (Deductible waived)	**Facility based Services:** $50 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Dialysis / Hemodialysis	No Charge (Deductible waived) *Savings Plus Plan Benefit*		No Charge (Deductible waived)
Gene/Cellular Therapy	Not Covered		
Home Infusion - Precertification Required	30% coinsurance after deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Infusion Therapy - Limited to $1,500 per date of service.	**Professional Non-Facility based Services:**	**Facility based Services:**	50% Coinsurance after Deductible

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Precertification required for certain services.	30% coinsurance after deductible *Savings Plus Plan Benefit*	30% coinsurance after deductible *Savings Plus Plan Benefit*	
Occupational Therapy - Limited to 30 visits per Calendar Year, visit limits are not combined with ASD diagnosis. Limits combined with PT. Developmental delays are covered. Combined Institutional /Professional. Combined In and Out of Network.	**Professional Non-Facility based Services:** $50 Copay / per visit (Deductible waived)	**Facility based Services:** $50 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Physical Therapy - Limited to 30 visits per Calendar Year, visit limits are not combined with ASD diagnosis. Limits combined with OT. Developmental delays are covered. Combined Institutional /Professional. Combined In and Out of Network.	**Professional Non-Facility based Services:** $50 Copay / per visit (Deductible waived)	**Facility based Services:** $50 Copay / per visit (Deductible waived) *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 30 visits per Calendar Year, visit limits are not combined with ASD diagnosis. Developmental delays are covered. Combined Institutional /Professional. Combined In and Out of Network	**Professional Non-Facility based Services:** $50 Copay / per visit (Deductible waived)	**Facility based Services:** $50 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Emergency Services			
Benefit	**In-Network & Out-Of-Network**		
Emergency Care	30% coinsurance after deductible *Savings Plus Plan Benefit*		
Urgent Care	$50 Copay / per visit (Deductible waived)	50% Coinsurance after Deductible	
Emergency Medical Transportation: Ground and Air Ambulance are covered.	30% coinsurance after deductible *Savings Plus Plan Benefit*		
Other Services			
Benefit	**In-Network**		**Out-Of-Network**

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Abortion - Therapeutic only. Dependent Children are covered.	**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	**Professional Non-Facility based Services:** 30% coinsurance after deductible	**Facility based Services:** 30% coinsurance after deductible	50% Coinsurance after Deductible
Allergy Services / Injections	**Professional Non-Facility based Services:** $50 Copay / per visit (Deductible waived)	**Outpatient / Inpatient Facility:** $50 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Allergy Testing	**Office Setting or Independent Lab:** $50 Copay / per visit (Deductible waived)	**Facility based Services:** $50 Copay / per visit (Deductible waived) *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Alternative Medicine	Not Covered		
Ambulance Service – Non Emergency Transport	30% coinsurance after deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Bariatric Surgery	Not Covered		
Biofeedback	Not Covered		
Blood Processing / Blood Storage/ 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 6 months of injury. Routine dental refer to Dental Carrier.	30% coinsurance after deductible		50% Coinsurance after Deductible
Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. Breast Pumps are covered at 100%.	30% coinsurance after deductible		50% Coinsurance after Deductible
Foot Care (non-routine)	**Professional Non-Facility based Services:** No Charge (Deductible waived) / per PCP Visit $50 Copay (Deductible waived) / per Specialist Visit	**Facility based Services:** No Charge (Deductible waived) / per PCP Visit $50 Copay (Deductible waived) / per Specialist Visit *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Gender Affirmation 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
Hearing Aids (exams, fittings, and device)	Not Covered		

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Hearing Exams – (routine and non-routine) ACA mandated Hearing exams are covered at 100% under PPACA. Limited to one exam per Calendar Year ages 22 and over.	**Professional Non-Facility based Services:** 30% coinsurance after deductible	**Facility based Services:** 30% coinsurance after deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Immunization – (non-routine)	Not Covered		
Infertility Services – (Basic Testing Only). Covered for services to diagnose infertility only; treatment of infertility is not covered.	**Office Setting or Independent Lab:** 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)	Not Covered		
Injections - Precertification may be Required.	**Professional Non-Facility based Services:** 30% coinsurance after deductible	**Facility based Services:** 30% coinsurance after deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Medical Nutrition Therapy	Not Covered		
Medical Nutrition Products	Not Covered		
Medical Supplies	30% coinsurance after deductible		50% Coinsurance after Deductible
Nutritional Counseling – Diabetic. When part of PPACA services refer to Preventive Care Benefits.	**Professional Non-Facility based Services:** 30% coinsurance after deductible	**Facility based Services:** 30% coinsurance after deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Nutritional Counseling – Nondiabetics When part of PPACA services refer to Preventive Care Benefits.	**Professional Non-Facility based Services:** 30% coinsurance after deductible	**Facility based Services:** 30% coinsurance after deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Online visits - Telephone consultations are excluded	No Charge (Deductible waived) / per PCP Visit $50 Copay (Deductible waived) / per Specialist Visit		50% Coinsurance after Deductible
Oral Surgery – Includes removal of impacted wisdom teeth. Dental Anesthesia is covered only if related to a payable oral 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
Orthotics and Prosthetic Devices – Diabetic shoes and Arch supports are not covered. Orthopedic- shoes are limited to 1 pair per year, inserts limited to 1 set every 24-month period.	30% coinsurance after deductible		50% Coinsurance after Deductible
Private Duty Nursing Year	Not Covered		
Respite Care	Not Covered		

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Retail Health Clinics	$50 Copay / per visit (Deductible waived)		
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	Not Covered		
TMJ Treatment - Surgical only, appliances 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
Vision Exams (Routine) and Hardware	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/ Toupees	Not Covered		

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	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.	Limited to $10,000 per transplant	Not Covered

Preauthorization
Anthem UM/CM: 1-800-336-7767
The following services require Preauthorization, or benefit will be reduced by 50%.
**this list is subject to change at the discretion of the Utilization Manager, Carelon Medical Benefits Management, Inc*

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

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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

Abortion - elective	Medical Nutrition Products
Alternative Medicine	Medical Nutrition Therapy
Bariatric Surgery	Non-Emergency Care in the ER Setting
Biofeedback	Non-Emergency Care outside the U.S.
Cosmetic Surgery	Private-Duty Nursing
Dental Care (Routine)	Respite Care
Gene/Cellular Therapy	Routine Foot Care
Hearing Aids (exams, fittings, and device)	Sleep Studies/Sleep Management Services
Home visits – (Professional)	Sterilization Reversals
Immunization – (non-routine)	Vision Exams (Routine) and Hardware
Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)	Weight Loss Programs
Long-Term Care	Wigs/ Toupees