Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Benefit	In-Network	Out-Of-Network
Plan Deductible	Individual: $2,500 Family: $5,000	Not Covered
Any Other Deductible	N/A	N/A
Deductible – Accumulation	Embedded	N/A
Deductible – INN and OON integration	N/A – No Out of Network Benefits	
Member Coinsurance	30%	N/A
Out of Pocket Maximum	Individual: $7,500 Family: $15,000	N/A
Out of Pocket – Accumulation	Embedded	N/A
Out of Pocket – INN and OON integration	N/A – No Out of Network Benefits	
Annual Benefit Maximum	Unlimited	N/A
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: Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)	Not Covered
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)	Not Covered
Children Eye Exam	No Charge (Deductible Waived)	Not Covered
Gynecological - Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)	Not Covered
Maternity (ACA Required Prenatal /Postnatal Testing/Services only)	No Charge (Deductible Waived)	Not Covered
Routine Immunizations (Child & Adult)	No Charge (Deductible Waived)	Not Covered
Flu Shot (Routine)	No Charge (Deductible Waived)	Not Covered
X-Rays and Lab tests (Routine)	No Charge (Deductible Waived)	Not Covered
Mammography (Routine) – 1 per plan year; Age 40 and more	No Charge (Deductible Waived)	Not Covered
Pap-smear (Routine) – 1 per plan year	No Charge (Deductible Waived)	Not Covered
Prostate Cancer Screening PSA (Routine) - 1 per plan year	No Charge (Deductible Waived)	Not Covered

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Colon Cancer Screening (Routine) - age 45-75 Colonoscopy – 1 in 10 years Sigmoidoscopy – 1 in 3 years	No Charge (Deductible Waived)	Not Covered

Non-Preventive Medical Services			
Benefit	**In-Network**		**Out-Of-Network**
Primary Care Physician Visits	**Professional Non-Facility based Services:** $25 Copay	**Facility based Services:** $25 Copay *Savings Plus Plan Benefit*	Not Covered
Specialist Physician Visits	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Maternity Professional: Hospital Stay Subject to Hospital Copay. Maternity Care for Dependent Children are not covered.	**Professional Non-Facility based Services**: $25 Copay per visit	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Chiropractic Care – Limited to 25 visits per Calendar Year	Office/Outpatient Settings: $60 Copay		Not Covered

Non-Preventive Lab and Radiology			
Benefit	**In-Network**		**Out-Of-Network**
Lab and Pathology	**Office Setting or Independent Lab:** No Charge	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
X-Rays / Radiology	**Office Setting or Independent Lab:** $50 Copay	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
MRI / MRA; CT / CTA / PET Scan; Genetic testing and counseling beyond ACA mandated is not covered.	**Office Setting or Independent Lab:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Sleep Studies/Sleep Management Services; Sleep Studies in the home are covered.	**Office, Independent Lab, or Home Setting:** $50 Copay *Savings Plus Plan Benefit*	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Inpatient Services		
Benefit	**In-Network**	**Out-Of-Network**
Pre-Surgical / Pre-Admission Testing	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab. Newborn not under mother for well newborn. Preauthorization is required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Inpatient Physician Services	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Cedarbridge Financial Services
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Inpatient Maternity Professional. Maternity Care for Dependent Children is not covered.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Anesthesia	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Surgery- Surgeon/ Assistant Surgeon Charges	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Detoxification Preauthorization is required	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Physical Medical Rehab	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Skilled Nursing Facility - Limited to 60 days per Calendar year. Required to follow IP Hospital stay of 3 days.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Outpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Second Opinion – Surgical	**Professional Non-Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist	**Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Outpatient Surgery Facility Preauthorization is required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Outpatient Surgery -Physician / Surgeon / Assistant Surgeon	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Anesthesia (including Office setting)	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Home Health Care - Patient required to be homebound. Home Health Aides are covered.	$60 Copay		Not Covered
Hospice – Facility and/or Home Limited to 210 days per lifetime. Precertification Required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
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.	**Office Professional & Outpatient Institutional:** $25 Copay	**IOP/PHP Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Cedarbridge Financial Services
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Effective Date: 01/01/2026

Therapy Services			
Benefit	**In-Network**		**Out-Of-Network**
ABA Therapy: Autism Spectrum disorder and Developmental delays are covered.	**Office Professional & Outpatient Institutional:** $25 Copay	**Facility based Services:** $25 Copay *Savings Plus Plan Benefit*	Not Covered
Cardiac Rehabilitation	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Chemotherapy– Provider may buy and bill. Excludes Orphan Drugs.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Dialysis / Hemodialysis Home Dialysis is covered.	**All Settings including Home Setting**: $60 Copay *Savings Plus Plan Benefit*		Not Covered
Gene/Cellular Therapy	Not Covered		Not Covered
Home Infusion – Visits count toward the Home Health Care visit limit of 60 per Calendar Year. Provider may buy and bill. Excludes Orphan Drugs.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Home visits – Professional (not part of Home Health visits/ Home Health Aid Services)	$25 Copay / per visit Non-Specialist $60 Copay / per visit Specialist		Not Covered
Infusion Therapy– Provider may buy and bill. Excludes Orphan Drugs.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Occupational Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays **are** covered. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Orthoptic / Pleoptic Therapy	Not Covered		Not Covered
Physical Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays are **covered**. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Pulmonary/Respiratory Therapy - Limited to 30 visits per Calendar year.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Radiation Therapy	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Speech Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays are covered. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Emergency Services			

LEADING EDGE ADMINISTRATORS

Cedarbridge Financial Services
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Benefit	**In-Network & Out-Of-Network**	
Emergency Care – ER Copay is waived if admitted.	$500 Copay *Savings Plus Plan Benefit*	
Urgent Care	$75 Copay	Not Covered
Emergency Medical Transportation: Ground, and Air Ambulance are covered.	$500 Copay *Savings Plus Plan Benefit*	

Other Services			
Benefit	**In-Network**		**Out-Of-Network**
Abortion - Elective & Therapeutic. Maternity Care for Dependent Children are not covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Acupuncture	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Allergy Services / Allergy Injections	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Allergy Testing	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Alternative Medicine	Not Covered		Not Covered
Ambulance Service – Non-Emergency Transport	Not Covered		Not Covered
Bariatric Surgery	Not Covered		Not Covered
Biofeedback	Not Covered		Not Covered
Blood Processing / Blood Storage Includes autologous donation	**Professional Non-Facility based Services**: No Charge	**Facility based Services:** No Charge *Savings Plus Plan Benefit*	Not Covered
Dental – Accident to sound teeth only. Treatment must be started within 12 months of injury. Routine Dental is excluded.	Office/Outpatient Settings: $60 Copay		Not Covered
Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. ACA Breast Pumps are covered at 100% All others at standard cost share.	30% Coinsurance after Deductible		Not Covered
Foot Care (routine)	Not Covered		Not Covered
Hearing Aids (exams, fittings, and device) ACA mandated Hearing exams are covered at 100% under PPACA.	Not Covered		Not Covered
Hearing Exams – non routine ACA mandated Hearing exams are covered at 100% under PPACA.	**Professional Non-Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist	**Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist *Savings Plus Plan Benefit*	Not Covered

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Immunization – (non-routine) Vaccinations for travel are excluded	**Professional Non-Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist	**Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Infertility Services - Basic Testing Only	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)	Not Covered		Not Covered
Injections– Provider may buy and bill. Excludes Orphan Drugs.	**Professional Non-Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist	**Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Medical Nutrition Therapy	Not Covered		Not Covered
Medical Nutrition Products: Enteral feeding supplies, formulae and all infant formulae are not covered.	Not Covered		Not Covered
Medical & Diabetic Supplies	30% Coinsurance after Deductible		Not Covered
Nutritional Counseling – Diabetic	**Professional Non-Facility based Services:** $25 Copay	**Facility based Services:** $25 Copay *Savings Plus Plan Benefit*	Not Covered
Nutritional Counseling – Nondiabetics	**Professional Non-Facility based Services:** $25 Copay	**Facility based Services:** $25 Copay *Savings Plus Plan Benefit*	Not Covered
Online visits - Telephone consultations are excluded	$25 Copay Non-Specialist $60 Copay Specialist		Not Covered
Onsite Clinics	Not Covered		Not Covered
Oral Surgery – Includes removal of impacted wisdom teeth. Dental anesthesia is covered if related to payable oral surgery.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Orthotics and Prosthetic Devices – Diabetic shoes, and Orthopedic shoes are not covered. Arch Supports are excluded	30% Coinsurance after Deductible		Not Covered
Private Duty Nursing	Not Covered		Not Covered
Respite Care	Not Covered		Not Covered
Retail Health Clinics	$25 Copay / per visit Non-Specialist $60 Copay / per visit Specialist		Not Covered
Sterilization – Men are covered. Women 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*	Not Covered
Sterilization Reversals	Not Covered		Not Covered
TMJ Treatment Non-surgical: Appliances are excluded	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered

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TMJ Surgical Treatment	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	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*	Not Covered
Wigs – limited to 1 per benefit period with a maximum of $3,000 post Chemotherapy or Radiation.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Transplant Services
Center 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	Not Covered	

Prescription Drug Benefits
Carelon Rx or 1-833-271-2374 www.carelonrx.com

Generic (Tier 1)	**No cost for Preventive Rx Drugs** **30-day supply:** $10 Copay **Mail Order up to 90-day supply:** $20 Copay	Not Covered
Preferred (Tier 2)	**30-day supply:** $50 Copay **Mail Order up to 90-day supply:** $100 Copay	Not Covered
Non-Limited/Non-Preferred (Tier 3)	**30-day supply:** 50% Coinsurance (Plan Deductible waived) **Mail Order up to 90-day supply:** 50% Coinsurance (Plan Deductible waived)	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 to 50% of the allowed.

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

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
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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
Managed Care Services:	Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty	Wound Vacs
Inpatient BH/SA	Botulinum Toxin – Review for Migraine Use Only	
Electric Convulsive Therapy (ECT)	Home Health Services	
Intensive Outpatient Therapy	Home Hospice	
Partial Hospitalization (PHO)	Hyperbaric Oxygen Therapy (Systemic/Topical)	
Residential Care (RTC)	Coronary CT Angiography (CCTA)	
Psychological testing	Coronary MRA	
Genetic Counseling	Cardiac MRI	
	MRA of the Head and/or Neck	
	MRI of the Brain	
	MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral	
	PET Scan	
	Physical/Occupational/Speech Therapy	

Exclusions

In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan

Acupuncture	Long-Term Care
Advanced and Comprehensive Infertility Services	Massage Therapy
Alternative Medicine/homeopathy	Maternity Care for dependent children
Aquatic Therapy	Maternity Care for dependent children
Arch supports (supportive shoe inserts)	Non-Emergency Care outside the U.S.
Bariatric Surgery	Non-Emergency Care in ER Setting
Biofeedback	Orphan Drugs
Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy)	Orthopedic Shoes/ orthopedic inserts – Non-diabetic
Custodial Care	Respite Care
Dental Care (Routine) Adult and Child except ACA allowed	Routine Eye Care (Adult) and Child except ACA allowed
Erectile Dysfunction	Self-Inflicted unless result of medical condition
Foot Care - Routine	TMJ Appliances
Gene and Cellular Therapy	Vision Exams and Hardware
Growth Hormone Therapy	Weight Loss Programs
Hearing Aids (exams, device, fitting, repairs)	