Population Science Management

MaxGuard Plan Comparison Summary

Limited Medical Plan
Effective Date: 11/01/2025

- EPO $300
- EPO $600
- EPO $900
- EPO $1,500
- EPO $2,000
- EPO $2,500

This illustration describes the plan in an easily understood manner and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the plan document or summary plan description, which contains more exact terms and detailed provisions of the plan; and it is not to be considered a policy of insurance.

Subject to plan allowable The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the monthly contributions) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.detegohealth.com or call 1-866-815-6001. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.com or www.cciio.cms.gov

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In-network Provider: First Health Network						
Payment for Services						
Covered Services are reimbursed based on the Allowable Charge. In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered Services, which are the Covered Person's responsibility. That means In-network providers, under the terms of their contract can't bill for amounts over the Contracted Amount. In some situations, Out-of-network Providers can bill for amounts over the Out-of-network allowance. Cost-sharing and reimbursement amounts for categories showing "Same as any other illness" may vary based on where services are rendered.						
Deductible • Individual • Family Unit*	 $300 $600	 $600 $1,200	 $900 $1,800	 $1,500 $3,000	 $2,000 $4,000	 $2,500 $5,000
Maximum Annual Benefit Amount • Yearly • Lifetime	 $1,000,000 $5,000,000	 $1,000,000 $5,000,000	 $1,000,000 $5,000,000	 $1,000,000 $5,000,000	 $1,000,000 $5,000,000	 $1,000,000 $5,000,000
Deductible (the amount the Covered Person pays each Benefit Period for Covered Services before the Coinsurance is payable)						
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)						
Out-of-Pocket Limit (includes Deductible, Coinsurance and Copays)						
In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently. Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the benefit period.						
*Unit/Accumulated – If you have family coverage, there is no individual Deductible or Out-of-pocket Limit. The total family Deductible and Out-of-pocket Limit must be met before the plan begins to pay for any covered services for any family member. All covered family members' expenses combine to meet these family amounts, and a single family member may contribute the entire total.						
Copays Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.						
Copayment(s) (copay(s)) apply to: • Physician Office • Specialist Office • Urgent Care Facility • Chemo/Radiation • Durable Medical Equipment • Therapies • Testing • Allergy Shots/Visits • Infusion/Injection Drugs • Mental Health/Substance Abuse Inpatient • Outpatient Services • Inpatient Services • Pregnancy Inpatient • Prosthetics/Orthotic • Emergency Services • Skilled Nursing Care • Home Health Care and Respiratory Care						
The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.						
All Benefits Payable Under This Plan Are Subject To The Plan Allowable.						
Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits.						
Precertification Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over $500), chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Please refer to the plan document for a complete list of all services that require precertification under your plan. A 50% (up to $2,500) penalty will apply for not obtaining precertification.						

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NETWORK	**IN**	**OUT**
Covered Services - Illness or Injury		
Physician Office Services 10 visit per member per benefit period. Maximum is combined for Virtual Physician office visits, PCP office visits, Specialist office visits, and Urgent Care visits, Mental Health/Behavioral Health/Autism/Substance Abuse office visits. • Primary Care Physician Office Visit • Specialist Physician Office Visit • Urgent Care Visit	$50 Copay (after deductible)	Not Covered
Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician. **Specialist Physician** is a physician who is not a Primary Care Physician. **Office Visit Benefits** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy), consultations and medication checks. **Physician Office Services** include but are not limited to: office visits; X-ray; laboratory and pathology services; Allergy Testing, Injections and Serums; Supplies and/or Drugs administered during the office visit; Hearing exams or Eye exams due to Illness or Injury excluding refractions. **Other Covered Services not part of the Physician Office Services Benefit (Refer to the appropriate category for benefit information) include:** Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy and Chemotherapy; Surgery and Anesthesia; Therapy and Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Mental Health and Substance Use Disorders.		
Telehealth/Virtual Care Services Through MyLiveDoc telehealth platform. • Virtual Primary Care - 12 visits limit per benefit period. • Urgent Care - Unlimited • Mental Health (Crisis intervention/triage only. Therapy not included.) - 4 visits limit per benefit period.	$0 Copay, $0 Deductible	Not Covered
NOTE: Unlimited Urgent Care visits use for MyLiveDoc Tele-Health Platform only. This does not include your physician's telemedicine services. Telemedicine used through your physician are considered visits and are included in the 10 visit maximum per benefit period.		
Emergency Services • Emergency Room Care - 3 visit limit per benefit period. • Emergency Medical Transportation - 1 visit per benefit period maximum. Combined for Ground and Air ambulance services.	$300 Copay (after deductible) $500 Copay (after deductible)	In-Network Level of Benefits (Not Covered if the visit was not an emergency.)
Outpatient Services • Outpatient Hospital/Ambulatory Surgical Center, All fees. - 3 surgeries per benefit period. Elective surgeries are not covered.	$250 Copay (after deductible)	Not Covered
Inpatient Services • Inpatient Hospital Services, Facility / Physician fees. - Paid at facility's semi-private room rate. Combined 3 hospitalizations per benefit period. 5 day limit per hospitalization. Elective surgeries are not covered. Combined with Mental Health/Behavioral Health/ Autism/Substance Abuse Inpatient hospital limits.	$850 Copay/Admission (after deductible)	Not Covered

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Preventive Care		
Preventive Care / Screening / Immunization • Affordable Care Act (ACA) required preventive services (may by subject to limits that include, but are not limited to, age, gender, and frequency).	$0 Copay, $0 Deductible	Not Covered
• ACA required covered preventive services (outside of limits).	Same as any other illness	Not Covered
• Other covered preventive services not required by ACA.	Same as any other illness	Not Covered
Mental Health, Behavioral Health and/or Substance Use Disorder Services		
Mental Health, Behavioral Health and/or Substance Use Disorder Services • Inpatient Services - Paid at facility's semi-private room rate. Combined 3 hospitalizations per benefit period. 10 day limit per hospitalization. Combined with annual Inpatient hospital limits.	$850 Copay/Admission (after deductible)	Not Covered
• Outpatient Services	Not Covered	Not Covered
• Partial Hospitalization	Not Covered	Not Covered
Office Services include office visits; medication checks; psychological therapy and/or substance use disorder counseling; x-rays; laboratory tests; supplies and/or drugs administered during the office visit. **Other Covered Services not part of the Office Benefit Services are covered under All Other Outpatient Items & Services.** This includes but is not limited to: psychological evaluations; assessments; testing; physical therapy; occupational therapy; speech therapy or any other covered Mental Health and/or Substance Use Disorder services.		
Other Covered Services - Illness or Injury		
Allergies • Shots - 12 Visits per benefit period.	$25 Copay (after deductible)	Not Covered
• Visits / Testing - 4 Visits per benefit period.	$100 Copay/Visit (after deductible)	Not Covered
Chemotherapy / Radiation 10 Visit limit combined with Infusion/Injectable Drugs.	$100 Copay/Visit (after deductible)	Not Covered
Child Dentistry and Eye Care • Child Eye Exam • Child Glasses / Contacts • Child Dental Check-Up	Not Covered	Not Covered
Diabetic Services • Diabetic Nutritional Counseling - 1 Visit per Plan Year.	$0 Copay (after deductible)	Not Covered
• Diabetic Supplies / Equipment - (through DiaThrive platform only.)	See DiaThrive information for more details	See DiaThrive information for more details
Dialysis	Not Covered	Not Covered
Durable Medical Equipment $500 Maximum per benefit period.	$100 Copay/Item (after deductible)	Not Covered

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NETWORK	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued 1 of 2)		
Home Health Care and Respiratory Care $500 Maximum per benefit period.	$50 Copay/Visit (after deductible)	Not Covered
Hospice Services $5,000 Maximum per benefit period.	$0 Copay (after deductible)	Not Covered
Infusion / Injection Drugs 10 Visit limit combined with chemotherapy/radiation.	$100 Copay/Visit (after deductible)	Not Covered
Organ Transplant Services	Not Covered	Not Covered
Pregnancy, Maternity		
• Routine Vaginal Delivery	$0 Copay (after deductible)	
• Routine C-Section Delivery	$0 Copay (after deductible)	
• Inpatient Facility - 2 days limit for Vaginal Delivery, 4 days limit for C-Section Delivery. Combined with annual hospitalization limits.	$850 Copay (after deductible)	
• Professional Services	$0 Copay (after deductible)	Not Covered
• Prenatal/Postnatal	$0 Copay (after deductible)	
• All Other Maternity Services	$0 Copay (after deductible)	
• NICU - 5 days limit.	Same as Inpatient Hospitalization	
NOTE: The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth. **NOTE:** Dependent Child pregnancy not covered.		
Prosthetics and Orthotic $2,500 Maximum per benefit period.	$250 Copay/Item (after deductible)	Not Covered
Skilled Nursing Care $5,000 Maximum per benefit period.	$50 Copay/Visit (after deductible)	Not Covered
Testing		
• Diagnostic Test (X-Ray, Lab, EKGs, ECGs, All other diagnostic services not included in Imaging) - 3 per benefit period.	$50 Copay (after deductible) Pre-certification Required.	Not Covered
• Imaging (CT/PET Scans, MRIs, MRAs) - 3 per benefit period.	$500 Copay (after deductible)	Not Covered

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NETWORK	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued 2 of 2)		
Therapy		
• Mental Health - 10 visits per member per benefit period. All-inclusive maximum is combined for Virtual Physician office visits, PCP office visits, Specialist office visits, and Urgent Care visits, Mental Health/Behavioral Health/ Autism/Substance Abuse office visits.	$50 Copay/Visit (after deductible)	Not Covered
• Spinal Manipulation Chiropractic - 16 visits per member per benefit period. All-inclusive maximum for Therapies (Chiropractic, PT/OT/ST, Cardiac (Pre-certifcation Required))	$50 Copay/Visit (after deductible)	Not Covered
• Physical Therapy - 16 visits per member per benefit period. All-inclusive maximum for Therapies (Chiropractic, PT/OT/ST, Cardiac (Pre-certifcation Required))	$50 Copay/Visit (after deductible)	Not Covered
• Occupational Therapy - 16 visits per member per benefit period. All-inclusive maximum for Therapies (Chiropractic, PT/OT/ST, Cardiac (Pre-certifcation Required))	$50 Copay/Visit (after deductible)	Not Covered
• Speech Therapy - 16 visits per member per benefit period. All-inclusive maximum for Therapies (Chiropractic, PT/OT/ST, Cardiac (Pre-certifcation Required))	$50 Copay/Visit (after deductible)	Not Covered
• Cardiac - 16 visits per member per benefit period. All-inclusive maximum for Therapies (Chiropractic, PT/OT/ST, Cardiac (Pre-certifcation Required))	$50 Copay/Visit (after deductible)	Not Covered
• Pulmonary Rehab - 16 visits per member per benefit period. All-inclusive maximum for Therapies (Chiropractic, PT/OT/ST, Cardiac (Pre-certifcation Required))	$50 Copay/Visit (after deductible)	Not Covered
All Other Covered Services	Deductible	Not Covered

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NETWORK	**IN**	**OUT**
Prescription Drugs		
Retail -per 30 day supply		
• Generic Drugs (Limited)	$0 Copay (Limited)	Not Covered
• Preferred Brand Name Drugs*	*PAP & SPIP Available	Not Covered
• Non-Preferred Brand Name Drugs*	*PAP & SPIP Available	Not Covered
Home Delivery		
• Generic Drugs (Limited)	ScriptCo	Not Covered
• Preferred Brand Name Drugs*	*PAP & SPIP Available	Not Covered
• Non-Preferred Brand Name Drugs*	*PAP & SPIP Available	Not Covered
Specialty Drugs	Not Covered	Not Covered

***NOTE:** Excluded and not covered medications: These medications may be separately available through our ancillary company, ScriptAide, using either their Patient Assistance Program (PAP) or Self-Pay Importation Program (SPIP).

Pharmacy Benefit Manager: These plans utilize Ventegra. Prescription drug list, Ventegra Mini-Mec Formulary.

Home Delivery: You can order a **30-day** or **90-day** supply of your prescriptions through ScriptCo.com. Detego Health contributes $6.00 toward each prescription, and you will be responsible for any remaining cost. To get started, register by claiming your membership through the email from ScriptCo. Prescribers can send prescriptions to **ScriptCo Pharmacy via E-Scribe** or **fax at 254-424-9800**. For questions or assistance, call ScriptCo at **888-201-0334**.

You can find this prescription drug list on detegohealth.com. Or you may contact Member Services at the phone number on the back of your I.D. card.

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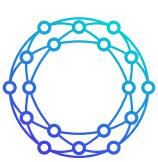
Limited Medical Plans · EPO · Monthly Contributions						
PLAN	**MaxGuard $300**	**MaxGuard $600**	**MaxGuard $900**	**MaxGuard $1,500**	**MaxGuard $2,000**	**MaxGuard $2,500**
AGES 18-29						
Employee	$329.00	$309.00	$289.00	$269.00	$249.00	$239.00
Employee + Spouse	$619.00	$599.00	$579.00	$559.00	$539.00	$519.00
Employee + Child(ren)	$599.00	$579.00	$559.00	$539.00	$519.00	$499.00
Family	$849.00	$809.00	$799.00	$789.00	$779.00	$769.00
AGES 30-44						
Employee	$379.00	$349.00	$329.00	$309.00	$279.00	$249.00
Employee + Spouse	$679.00	$639.00	$619.00	$599.00	$579.00	$549.00
Employee + Child(ren)	$649.00	$619.00	$589.00	$569.00	$549.00	$529.00
Family	$909.00	$879.00	$839.00	$809.00	$799.00	$789.00
AGES 45-54						
Employee	$409.00	$379.00	$359.00	$339.00	$319.00	$289.00
Employee + Spouse	$699.00	$679.00	$659.00	$639.00	$629.00	$619.00
Employee + Child(ren)	$679.00	$649.00	$629.00	$619.00	$599.00	$579.00
Family	$929.00	$899.00	$889.00	$869.00	$849.00	$829.00
AGES 55-64						
Employee	$449.00	$429.00	$409.00	$389.00	$369.00	$349.00
Employee + Spouse	$709.00	$689.00	$669.00	$649.00	$639.00	$629.00
Employee + Child(ren)	$689.00	$659.00	$639.00	$629.00	$609.00	$589.00
Family	$949.00	$929.00	$909.00	$889.00	$869.00	$859.00

Notes

Notes



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