Benefit Summary

Business Name: AMD SENIOR PURECARE LLC DBA AMD HOME CARE
Agent: Rutul Sheth
Agent Phone: (267) 625-5969
Proposal Creation Date: 01/28/2026
County: MONTGOMERY
State: PA ZIP 19040
Proposed Effective Date: 03/01/2026
HCR Indicator:
Size Category: S
Location Name: Location 1
Location Type: Main
SIC Code: 80800

Plan 1	
Plan type: As a member of the Advantage plan, members must use the doctors and hospitals within the PPO network to receive benefits. There are no out-of-network benefits.	
Medical Network	Cigna OAP www.cigna.com
Individual Deductible	$3,500
Family Deductible	$7,000
Family Deductible Accumulation Method	Embedded deductible
Plan Coinsurance Percentage (plan pays)	70%
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$5,600
Total Individual out-of-pocket maximum	$9,100
Total Family out-of-pocket maximum	$18,200
Lifetime Benefit Maximum	No maximum
Office Visit (does not require a referral)	$40 primary care provider copay, then covered at 100%/$60 specialist copay, then covered at 100%
Recuro Health Virtual Services **Virtual Urgent Care:** U.S. board-certified doctors and medical providers are available 24/7/365 to diagnose, treat and prescribe medication (when necessary) for many minor illnesses and injuries via phone or online video visits. **Virtual Counseling:** Licensed therapists can help with a wide range of mental and emotional health needs. Receive ongoing support, on your schedule, from the comfort and privacy of your own home via phone or online video visits in as little as 48 hours.	$0 per visit for Virtual Urgent Care or Virtual Counseling visits
Vori Health A nationwide specialty medical practice delivering virtual-first muscle and joint pain solutions to help members get back to their lives faster. With Vori Health, members will get treatment from a specialty physician, physical therapist, and health coach who work together to manage all aspects of care. This holistic model reduces unnecessary surgeries, lowers spend, and improves outcomes.	$0 copay for initial evaluation $0 copay for 12-month treatment plans for knee, lumbar spine, cervical spine, hip, and/or shoulder pain Other Vori Health covered charges subject to deductible and coinsurance
Pharmacy Benefit Manager	CIGNA PBM

The Self-Funded Program through Nationwide provides tools for employers owning small to midsized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. Stop loss insurance policies are underwritten by Nationwide Life and Benefits Insurance Company, Columbus OH, in AK, AR, AZ, CT, IL, MA, PA, TX, WI; Integon National Insurance Company in NY; and National Health Insurance Company in CO, WA and all other states where offered. Product availability and specific provisions may vary by state. Nationwide and the Nationwide N and Eagle are service marks of Nationwide Mutual Insurance Company. © 2026 Nationwide nationwide.com | nationwide.com/grouphealth

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Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$65/$100
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations.	Paid at 100% - no deductible, coinsurance
Urgent Care Visit	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use	Deductible and coinsurance
Maternity	Deductible and coinsurance
Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse (Inpatient)	Deductible and 70% coinsurance. Limited to 30 days.
Behavioral Health and Substance Abuse (Outpatient)	Deductible and 70% coinsurance. Office visits are considered at the primary care copay level. Limited to 40 visits per year
Inpatient and Outpatient Hospital, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services**	Deductible and coinsurance

** For an emergency medical condition, charges for emergency treatment and emergency confinement received from an out-of-network provider will be paid as if services were received by an in-network provider until the patient's condition has stabilized, subject to the plan's maximum allowable amounts.

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The following information applies to all the medical plans contained in this Proposal and dental or vision plans when denoted:

Additional Information

Utilization Review

When inpatient treatment is needed, the covered person is responsible for calling to receive authorization. The toll-free telephone number appears on the insurance ID card. If authorization is not received, a penalty will be applied. Please refer to the SPD for specific details. No benefits are paid for transplants which are not authorized. Authorization is not a guarantee of coverage.

Deductible Credit

When coverage first begins, credit is given for any portion of a calendar-year deductible satisfied under the prior plan during the same calendar year, except when the deductible credit is waived. However, no credit is given for past policy-year deductibles.

If a dental option or dental with vision option is selected, deductible credit may also be available.

New Hires

For groups with a 0, 30 or 60 day employment waiting period, new eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date: First day of the billing month following the date of full-time employment, when the enrollment request is received within 31 days of this date. For groups with a 90 day employment waiting period, newly eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date: The 90th day following the date of full-time employment, when the enrollment request is received within 31 days of the expiration of the employment waiting period.

If a dental option or dental with vision option is selected, the same new hire waiting period will apply.

Medical Exclusions Summary

- For Advantage plans, any charges that are provided or performed by a Health Care Practitioner, facility, or supplier that is not identified for the Health Care Provider Network as a Participating Provider, Participating Pharmacy, Specialty Pharmacy Provider, or Designated Transplant Provider. This exclusion does not apply to PPO plans that cover charges for treatment provided or performed by either Participating Providers (In-network) or Non-Participating Providers (Out-of-network).
- Treatment not listed in the summary plan description
- Services by a medical provider who is an immediate family member or who resides with a covered person
- Charges for services, supplies or drugs provided by or through any employer of a Covered Person or of a Covered Person's family member
- Treatment reimbursable by Medicare, Workers' Compensation, automobile carriers or expenses for which other coverage is available
- Routine hearing care, vision therapy, surgery to correct vision, foot orthotics, or routine vision care and foot care unless part of the diabetic treatment
- Charges for custodial care, private nursing, telemedicine or phone consultations with the exception of Recuro Health Virtual Services or One Medical Virtual services if purchased as part of your plan, or Telehealth (virtual) visits
- Charges for diagnosis and treatment of infertility except for groups of 51 or more that are administered by Allied or Meritain on the traditional or Advantage plans
- Charges for surrogate pregnancy or sterilization reversal
- Charges for cosmetic services, including chemical peels, plastic surgery and medications
- Charges for umbilical cord storage, genetic testing, counseling and services
- Treatment of "quality Of life" or "lifestyle" concerns including but not limited to obesity, hair loss, restoration or promotion of sexual function, cognitive enhancement and educational testing or training
- Over-the-counter drugs, (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider), drugs not approved by the FDA, drugs obtained from sources outside the United States, and the difference in cost between a generic and brand name drug when the generic is available
- Complications of an excluded service
- Charges in excess of any stated benefit maximum
- Treatment of an illness or injury caused by acts of war, felony, or influence of an illegal substance
- Dental care not related to a dental injury (specific to medical coverage)
- Non-surgical treatment for TMJ or CMJ other than that described in the contract, or any related surgical treatment that is not pre-authorized
- Any correction of malocclusion, protrusion, hypoplasia or hyperplasia of the jaws
- Charges for cranial orthotic devices, except following cranial surgery
- Charges for medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section
- Charges for devices or supplies, except as described under a Prescription Order
- Charges for prophylactic treatment
- Charges related to health care practitioner-assisted suicide
- Charges for growth hormone stimulation treatment to promote or delay growth
- Charges for treatment of behavioral health or substance abuse, except as otherwise covered in the Behavioral Health and Substance Abuse provision in the Medical Benefits section
- Charges for testing and treatment related to the diagnosis of behavioral conduct or developmental problems; charges for applied behavioral analysis
- Charges for alternative medicine, including acupuncture and naturopathic medicine (except when optional acupuncture and naturopathic medicine coverage is purchased)
- Charges for chelation therapy
- Charges for experimental or investigational services

This form contains a partial summary of information for the health benefit plan templates. For a complete listing of employee health benefits, exclusions and limitations please refer to the medical summary plan description. Please refer to the stop-loss policy for a complete listing of employer stop-loss benefits, exclusions and terms of coverage. In the event that there are discrepancies with the information in this form, the terms and conditions of the coverage documents will govern.

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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 premium) 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, visit us at www.alliedbenefit.com or call 1-888-292-0272. 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 https://www.healthcare.gov/sbc-glossary or call 1-888-292-0272 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers $3,500 individual/$7,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $9,100 individual/$18,200 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalty for not obtaining Preauthorization and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a participating provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit, then covered at 100%	Not covered	Copayment is not subject to any Deductible. Copay applies to exam charge only. Does not include office surgery.
	Specialist visit	$60 copay/visit, then covered at 100%	Not covered	Copayment is not subject to any Deductible. Copay applies to exam charge only. See Plan Document for other services.
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	Not covered	As required under the Affordable Care Act(ACA), cost sharing does not apply to identified clinical preventive services. Any other preventive medicine services covered under your plan are subject to deductible and coinsurance. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Preauthorization is required. If not received, a penalty will be applied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com	Generic drugs (Tier 1)	$20 copay retail/$60 copay mail order	Not covered	When the retail store offers a lower price for generic, pay only the lower price. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$65 copay retail/$195 copay mail order	Not covered	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Non-preferred brand drugs (Tier 3)	$100 copay retail/$300 copay mail order	Not covered	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Specialty drugs (Tier 4)	30% coinsurance	Not covered	To receive the network provider benefit, you must obtain specialty drugs from a specialty pharmacy provider as designated by us. Call 1-800-MyCigna for further information. Specialty drugs obtained from a non-designated specialty pharmacy provider will not be covered. Authorization is required. Benefits will not be paid for any specialty drugs that are not authorized by the Medical Review Manager.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Preauthorization is required. If not received, a penalty will be applied.
	Physician/surgeon fees	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Non-emergency use will result in a reduction of charges up to the preauthorization penalty amount. The penalty is not covered.
	Emergency medical transportation	30% coinsurance	30% coinsurance	To the nearest Acute Medical Facility that can treat the sickness or injury.
	Urgent care	$75 copay/visit, then covered at 100%	Not covered	Copayment is not subject to any Deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Preauthorization is required. If not received, a penalty will be applied.
	Physician/surgeon fees	30% coinsurance	Not covered	Preauthorization is required. If not received, a penalty will be applied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit, then covered at 100%. 30% coinsurance for other services.	Not covered	Limited to 40 visits per year. Copayments apply to the office visit charge only. Any other services covered under your plan are subject to deductible and coinsurance.
	Inpatient services	30% coinsurance	Not covered	Preauthorization is required. If not received, a penalty will be applied. Limited to 30 days per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	$60 copay/visit, then covered at 100%	Not covered	Copayment is not subject to any Deductible. Copay applies to exam charge only. See Plan Document for other services.
	Childbirth/delivery professional services	30% coinsurance	Not covered	None
	Childbirth/delivery facility services	30% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Preauthorization is required. If not received, a penalty will be applied. Limited to 60 visits per year.
	Rehabilitation services	30% coinsurance	Not covered	Preauthorization is required for Inpatient. If not received, a penalty will be applied. Inpatient limited to 31 days per year. Outpatient limited to 30 visits per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Habilitation services	30% coinsurance	Not covered	Preauthorization is required for Inpatient. If not received, a penalty will be applied. Inpatient limited to 31 days per year. Outpatient limited to 30 visits per year.
	Skilled nursing care	30% coinsurance	Not covered	Preauthorization is required. If not received, a penalty will be applied.
	Durable medical equipment	30% coinsurance	Not covered	Preauthorization is required for amounts greater than $1,500. If not received, a penalty will be applied.
	Hospice services	30% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental checkup	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult), except for treatment of diabetes
- Routine foot care, except for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: contact the plan at 1-888-292-0272 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-888-292-0272 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform.

Does this Plan Provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan Meet the Minimum Value Standard? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-292-0272.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-292-0272.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-292-0272.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-292-0272.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg Is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3.500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic Tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,270**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3.500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3.500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Dental Quote

AMD SENIOR PURECARE LLC DBA AMD HOME CARE

Plan: SmartPremium 100/80/50-1000 MAC

Policy effective date: 2026-04-01

Policy length: 12 months

Minimum employer contributions: 0.0% for employee and 0.0% for dependent(s).

Quote id: 740425

Plan quote id: 9272065

Class: All Full-time Active Employees

Plan pricing

Employee	Employee + spouse	Employee + children	Family
$28.76 monthly	$57.52 monthly	$72.81 monthly	$101.57 monthly

Why Beam Benefits

With Beam, you get simpler, smarter employee benefits. Our plans are easy to understand, easy to implement, and even easier to use with technology when you want it and helpful support from real people when you need it.

- Digital-first, rapid implementation
- A national network of more than 500,000 access points. Find an in-network Dentist
- Self-service online administration management tool

Plan coverage

	In-network (PPO fee)	Out-of-network (PPO Fee)
Preventive & Diagnostic **Diagnostic and preventive**: exams, cleanings, fluoride, space maintainers, x-rays, and sealants	100%	100%
Basic **Emergency palliative treatment**: to temporarily relieve pain **Minor restorative**: fillings **Prosthetic maintenance**: relines and repairs to bridges and dentures	80% *After deductible*	80% *After deductible*
Major **Endodontics**: root canals **Implants**: endosteal in lieu of a 2 or 3 unit bridge **Major restorative**: crowns, inlays, and onlays **Oral surgery**: extractions and dental surgery **Periodontics**: to treat gum disease **Prosthetics**: bridges **Prosthodontics**: dentures	50% *After deductible*	50% *After deductible*

Plan maxes

Annual maximum is the most Beam will pay in a policy year, and applies to diagnostic & preventive, basic services, and major services. **Annual max based on Calendar Year**.

Annual max (In network)	$1,000/yr
Annual max (Out of network)	$1,000/yr

Plan deductible

The deductible is the dollar amount paid towards the cost of care before the insurance benefit begins to cover the cost of claims. The deductible is waived for diagnostic & preventive services.

Individual	$50/yr
Family	$150/yr

Additional details

See any dentist
Our PPO plans allow you to see any licensed dentist. Savings in plan cost and member out of pocket expenses may be obtained by utilizing participating network dentists.

Beam has partnered with leading regional and national PPO network partners through Dental Benefit Providers (DBP), Careington, DenteMax Plus, Connection Dental, First Dental Health, Maverest, and Beam Direct networks to provide you with the most choices possible.

Rating Requirements

Minimum employer contributions: 0.0% for employee and 0.0% for dependent(s).

Minimum employee enrollment: 2 employees

Maximum number of subgroups: 10

Rates are valid for 90 days after 02/11/26

Frequencies & limitations

Coverage rules

Code	Procedure	Covered Under	Frequency	Notes
D0120, D0150, D9310	Periodic oral exam, Comprehensive oral exam, Consultation	Diagnostic	Limit of 2 per 12 months	Limited to 2 oral evaluation procedures, in any combination (D0120, D0150, D9310) per 12 month period
D0150	Comprehensive oral exam	Diagnostic	One per 60 months per provider	
D0140	Limited oral exam	Diagnostic	Two per 12 months	Can do treatment on same day; no shared freq with D0120; shared freq with D0170
D0210	Radiographs-FMX	Diagnostic	One per 60 months	Shared freq with D0330; not reimbursed within 6 months of Bitewing Radiographs
D0220	Radiographs-periapical (first)	Diagnostic	Not covered if inclusive of a procedure with x-rays.	Bitewings and 7 or more periapicals will be reimbursed as FMX. Not covered on same day as D0210, D0330 or if considered a part of billed procedures
D0230	Radiographs-periapical (each additional)	Diagnostic	Not covered if inclusive of a procedure with x-rays.	Bitewings and 7 or more periapicals will be reimbursed as FMX. Not covered on same day as D0210, D0330 or if considered a part of billed procedures
D0270-D0274	Radiographs-bitewings	Diagnostic	Every 6 months	Can perform 6 months after D0210
D0330	Radiographs-panoramic	Diagnostic	One per 60 months	Shared freq with D0210
D1110	Prophylaxis	Preventive	Two per benefit period	Three per 12 months if pregnant 2nd/3rd trimester, four per 12 months if diabetic (N, V); not covered within 3 months of D4910
D1206, D1208	Fluoride	Preventive	Two per 12 months	Covered under age 16
D1351, D1352	Sealants, Resins	Preventive	One per 36 months, per tooth	Covered under age 16, 1st & 2nd permanent molars
D2140-D2161	Fillings	Minor Restorative	One per 24 months, per tooth	Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations.
D2330-D2394	Fillings	Minor Restorative	One per 24 months, per tooth	Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. Posterior composites covered.
D2740, D2750 ...	Crowns (N,X,A)	Major	One per 60 months, paid on seat date; seat date required	See * note below for details
D2950	Core Build-up (X)	Major	One per 60 months	See * note below for details
D4341-D4342	Periodontal scaling and root planing (N, P, X)	Periodontics	One per 24 months, per quadrant	Can perform all 4 quads in one day
D4910	Periodontal maintenance (H)	Periodontics	Two per year unless pregnant (3) or diabetes (4)	After peridontal treatment; can be alternated with D1110 for one per three months
D6010	Endosteal Implants (N,M,X2)	Major	One per lifetime	In lieu of a single tooth replacement when a 2 or 3 unit bridge has been approved for coverage when adjacent teeth are not in need of crowns on their own merit; if there are no additional teeth missing throughout the arch. Alternate benefit of a partial denture will be considered if criteria is not met.

Not covered: D0350, D0364, D0470, D1330, D2962, D3110, D3120, D8093, D9230, D9248
*Exclusions include, but are not limited to: correction of attrition, abrasion, erosion, or abfraction; for teeth that are not broken down by extensive decay or accidental injury; to restore teeth with microfractures fracture lines, undermined cusps, or existing large restorations without overt pathology.

Frequently asked questions

Continuation of service?	Covered starting on patient's effective date	**N** = Narrative of medical necessity
Continuation of benefits?	Earlier effective date is primary	**P** = Perio charting
Frequency of ortho payments?	Monthly – submit claims for on-going treatment	**X** = Labeled & dated, pre-op x-rays
Are prior extractions covered?	Yes – no missing tooth clause	**X2** = Labeled & dated, pre-op and post op x-rays
Timely Filing limit?	12 months from date of service unless otherwise specified by state law. Please refer to your Certificate	**H** = Periodontal history
Is pre-authorization mandatory?	No – but estimates recommended for $300+ services	**A** = date of prior insertion of existing crown
		M = panoramic x-ray or FMX (if available), all missing teeth
		V = Verification from physician (if pregnant requires due date)

Disclaimer

This quote is not a complete description of the insurance coverage. Controlling provisions are provided in the policy, and this quote does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this quote and the contract, the contract will govern.

Unless otherwise requested, the producer that you designate as your broker of record will receive commission as a percentage of paid premium for the insurance policies included in this quote. The producer may also qualify for bonuses based on new policies sold and/or retention of existing policies within a specific calendar year. This compensation may vary on a number of factors, including the volume and/or profitability of the insurance contracts that the producer places with Beam Insurance Services LLC. Any bonuses paid are not directly charged to the insurance policies included in this quote and do not have a direct impact on your premium rate. You may obtain information about the compensation expected to be received by the producer by requesting such information from your broker of record.

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THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY.

Two life groups made up of only a husband-wife, domestic partners or same-sex couple are not eligible for coverage.

National Guardian Life Insurance Company, Madison, WI, is not affiliated with The Guardian Life Insurance Company of America, a.k.a. The Guardian, or Guardian Life.

Nationwide and Beam Insurance Services LLC are separate and non-affiliated companies.

National Guardian Life Insurance Company, Two East Gilman, Madison, Wisconsin 53703

Nationwide Life Insurance Company, One Nationwide Plaza, Columbus, OH 43215

Vision Quote

AMD SENIOR PURECARE LLC DBA AMD HOME CARE

Plan: VSP® Choice Plan #1

Policy effective date: 2026-04-01
Policy length: 24 months
Minimum employer contributions: 0.0% for employee and 0.0% for dependent(s).
Contract length: 24 months
Quote id: 740425
Plan quote id: 4387223
Class: All Full-time Active Employees

Plan pricing

Employee	Employee + spouse	Employee + children	Family
$6.59 monthly	$13.16 monthly	$13.93 monthly	$22.32 monthly

Frequency

Exam every	12 months
Lenses every	12 months
Frames every	24 months
Contacts (instead of glasses)	12 months

Co-payments

Exam	$10
Materials	$25
Contact lens fitting & evaluation	15% discount (not to exceed $60)

In-network allowances

Retail frame value[1,2]	$150 / 20% savings on amount over allowance
Elective contact lens materials	$150
Covered lens enhancements	Polycarbonate for Children

Value added programs

Diabetic Eyecare Plus Program℠	Included
Low vision	Included
Hearing aid discounts	Included
Health-focused care	Included
Diabetic exam reminder letters	Included

Out-of-network allowances

Examination, up to	$45
Single vision lenses, up to	$30
Bifocal/progressive lenses, up to	$50
Trifocal lenses, up to	$65
Lenticular lenses, up to	$100
Frames, up to	$70
Elective contact lens materials and fitting/evaluation, up to	$105
Necessary contact lenses, up to	$210

Extra discounts & savings[2]

Lens enhancements	Average savings of 30% on other lens enhancements
Additional pair of glasses or sunglasses	20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam®.
Laser vision correction (lvc)	15% discount avg.

1. Coverage with a retail chain may be different or does not apply.
2. Added value services are additional benefits offered by VSP and not included in the insurance benefit plan.

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Nationwide Life Insurance Company, One Nationwide Plaza, Columbus, OH 43215

Vision Service Plan Insurance Company, 3333 Quality Drive Rancho Cordova, CA 95670