Dual Option Platinum PPO

2026 Plan Guide for Representatives and Members

PLAN NAME	Dual Option Platinum PPO
PLAN YEAR	January 1 - December 31, 2026
TIER 1 NETWORK	Northwell Direct
TIER 2 NETWORK	Anthem Blue Cross Blue Shield (PPO)
PLAN ADMINISTRATOR	International Benefits Administrators (IBA)
PHARMACY BENEFITS	CarelonRX
LIFE INSURANCE	Prudential - $7,000 Term Life (included)
DEATH BENEFIT	$4,000 (included)

Inside: plan summary | how the plan works | 2026 rates | benefit details | prescription coverage exclusions | pre-certification | eligibility and enrollment | plan partners and FAQ

This guide is a summary. The official Plan Document / Summary Plan Description governs in the event of any discrepancy.

Dual Option Platinum PPO

One-Page Plan Summary

Coverage Tier	Monthly Rate
Single	$1,115.00
Employee + Spouse	$2,087.00
Employee + Child(ren)	$1,891.00
Family	$2,923.00

Plus $10/mo admin fee (not included in rate). One-time enrollment fee: $125, or $250 for groups of 2+.

Plan highlights

- **$0 deductible** at Northwell Direct (Tier 1); **nationwide** Anthem BCBS PPO (Tier 2)
- **No referrals**; no PCP designation required
- **Free 24/7 virtual care** (CirrusMD); preventive care **100%** in network
- Medical + Rx share **one combined** OOP max; family limits are **embedded**
- Deductibles paid in Tier 2 also count toward Tier 1 & 2
- Dependent children covered to **age 26**; newborns must be added **within 31 days**
- Emergencies always paid at network level — anywhere in the U.S.
- Includes **$7,000 term life** (Prudential) + a **$4,000 death benefit**
- Available to employer groups, single-member LLCs, C Corps, S Corps & Schedule C sole props
- Not covered: adult dental/vision, hearing aids, bariatric surgery, infertility treatment, specialty drugs — the Plan Exclusions page has the full list

Benefit snapshot	Tier 1: Northwell Direct	Tier 2: Anthem BCBS	Out-of-Network
Deductible (Ind / Fam)	**$0 / $0**	$500 / $2,000	$1,000 / $2,000
Out-of-Pocket Max (Ind / Fam)	$6,000 / $18,200	$6,000 / $18,200 (combined w/ Tier 1; includes Rx)	$9,200 / $18,200
Coinsurance (plan pays)	100%	100%	70% after deductible
PCP / Specialist office visit	$25 / $40 copay	$35 / $50 copay	Ded., then 30%
Preventive care & telehealth (CirrusMD)	No charge	No charge	Ded., then 30%
Urgent care	$50 copay	$75 copay	Ded., then 30%
Emergency room / ER physician	$600 copay (waived if admitted) / No charge	$600 copay / No charge	$600 copay / No charge
Ambulance (emergency, ground or air)	$600 copay	$600 copay	$600 copay
Inpatient hospital — facility*	$500 copay per admission	Ded., then $1,000 copay per admission	Ded., then 30%
Inpatient physician visits	$40 copay	Ded., then $50 copay	Ded., then 30%
Outpatient surgery — facility / surgeon*	$500 copay each	Ded., then $1,000 copay each	Ded., then 30%
Lab / X-ray (minor diagnostics)	$40 / $50 copay	Ded., then $50 / $75 copay	Ded., then 30%
Advanced imaging (MRI, CT, PET)*	$400 copay	Ded., then $600 copay	Ded., then 30%
Maternity — prenatal / delivery facility*	No charge / $500 per admission	No charge / Ded., then $1,000	Ded., then 30%
Mental health & SUD — office / inpatient*	$40 / $500 per admission	$50 / Ded., then $1,000	Ded., then 30%
PT / OT / Speech (50 visits/yr)*	$40 copay	Ded., then $50 copay	Ded., then 30%
Chiropractic (30 visits/yr)	$50 copay	Ded., then $75 copay	Ded., then 30%
Durable medical equipment*	$400 copay	Ded., then $500 copay	Ded., then 30%
Rx — retail 30-day (L1 / L2 / L3)	$10 / $50 / $80	$10 / $50 / $80	Not covered
Rx — mail order 90-day (L1 / L2 / L3)	$30 / $150 / $240	$30 / $150 / $240	Not covered

* Pre-certification required through WellGuide Health — claims are denied if required pre-certification is not obtained (retro review available within 90 days). Injectable drugs: 30% coinsurance; specialty drugs not covered.

How the Plan Works

A two-tier PPO built around direct contracting — lower costs when members choose Northwell, nationwide coverage everywhere else.

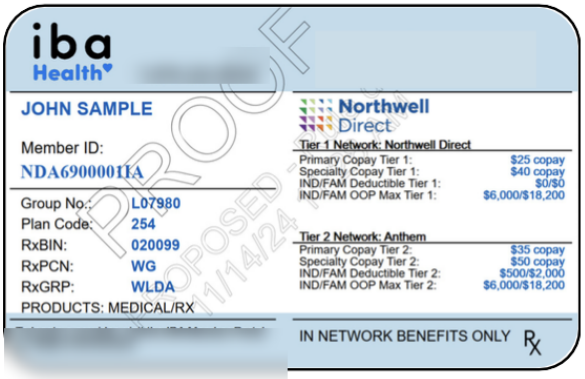
TIER 1 **Northwell Direct**	**Lowest cost.** Direct contracts with Northwell hospitals, facilities, and physicians. **$0 deductible**, fixed copays, and the plan pays 100% after your copay. A provider directory is included with your member materials.
TIER 2 **Anthem BCBS**	**Nationwide access.** The Blue Cross Blue Shield PPO network covers over 95% of doctors and 96% of hospitals across the U.S. A modest **$500 individual / $2,000 family** deductible applies to most services; office visits and preventive care are covered before the deductible.
OUT OF NETWORK	**Highest cost.** After a $1,000 / $2,000 deductible the plan pays 70% of the allowed amount; members may be balance-billed above the plan's Maximum Allowable Charge. Emergency care and No Surprises Act claims are always paid at the network level.

Good to know

- **No referrals.** Members may see any specialist without a referral, in any tier.
- **Deductibles cross-apply.** Amounts paid toward the Tier 2 deductible also count toward Tier 1 and Tier 2; Tier 1 has no deductible of its own. In- and out-of-network deductibles accumulate separately.
- **One combined out-of-pocket maximum.** Tier 1 and Tier 2 medical costs and prescription drug costs all accumulate to the same $6,000 individual / $18,200 family cap. Once reached, the plan pays 100% for the rest of the calendar year.
- **Embedded family limits.** No individual family member ever pays more than the individual deductible or out-of-pocket maximum.
- **Network-referred exceptions.** If a network provider sends lab work, x-rays, or anesthesia to a non-network provider, the plan pays it at the network level.
- **Emergency care is protected.** Out-of-area emergencies and emergency care at non-network hospitals are paid at the network benefit level.

Reading the ID card

Every member receives an ID card showing both networks. The front carries the member ID, group and plan numbers, pharmacy routing codes, and tier-by-tier copays. The back lists every service contact and claim-filing address a member will need — complete contact information arrives with the card after enrollment and approval. Tier 1 claims are submitted to the plan administrator; Anthem (Tier 2) providers file with the Blue Cross Blue Shield plan in the state where services are rendered.



Sample Dual Option Platinum PPO ID card (front) — proof shown; actual cards are personalized.

2026 Monthly Rates

Dual Option Platinum PPO — rates effective January 1, 2026 through December 31, 2026.

Coverage Tier	Who It Covers	Monthly Rate
Single	Employee only	**$1,115.00**
Employee + Spouse	Employee and legal spouse	**$2,087.00**
Employee + Child(ren)	Employee and eligible dependent child(ren)	**$1,891.00**
Family	Employee, spouse, and eligible dependent child(ren)	**$2,923.00**

Additional Fees	Amount	When
Administrative fee	$10 per month	Monthly — in addition to the rates above (not included in rate)
Enrollment fee	$125 one-time, or $250 for groups of 2 or more	One time, at enrollment

Billing and account changes: Nuera Benefits Agency handles billing, eligibility, and demographic changes (address updates, adding or removing dependents, coverage-tier changes). Contact information is provided upon enrollment and approval.

INCLUDED WITH ENROLLMENT: Every enrolled member receives a **$7,000 Term Life Insurance** benefit issued by Prudential and a **$4,000 death benefit** — both at no additional cost. Beneficiaries are designated on the enrollment membership form and may be updated at any time.

About the Plan

The Dual Option Platinum PPO is the richest design in the Northwell Direct lineup: no deductible in Tier 1, first-dollar copays for everyday care, 100% plan coinsurance in network, and full nationwide PPO access in Tier 2. Dependent children are covered to age 26. Coverage is self-funded and administered by International Benefits Administrators, with utilization review by WellGuide Health and pharmacy benefits through CarelonRX. Enrollment also includes a $7,000 term life insurance benefit issued by Prudential and a $4,000 death benefit.

Real-world cost examples (from the official SBC)

Scenario	Total Example Cost	Member Pays
Having a baby — 9 months of Tier 1 prenatal care and hospital delivery	$12,700	$1,145
Managing type 2 diabetes — a year of routine Tier 2 care, well-controlled	$5,600	$1,590
Simple fracture — Tier 1 ER visit with follow-up care	$2,800	$1,580

Coverage examples are illustrations from the Summary of Benefits and Coverage, based on self-only coverage; actual costs vary.

Medical Benefits in Detail

Per participant, per calendar year. All benefits subject to plan provisions and the Maximum Allowable Charge. Out-of-network: deductible then 30% member coinsurance unless noted.

OFFICE & PROFESSIONAL	Tier 1: Northwell Direct	Tier 2: Anthem BCBS	Limits / Notes
PCP office visit	$25 copay	$35 copay	
Specialist office visit	$40 copay	$50 copay	No referral needed
Telehealth (CirrusMD)	No charge	No charge	Other online visits are not covered
Preventive care	No charge	No charge	ACA-required services at 100%
Chiropractic care	$50 copay	Ded., then $75 copay	30 visits per year
Allergy testing	PCP/Spec copay	PCP/Spec copay	Allergy injections/serum not covered

DIAGNOSTICS	Tier 1: Northwell Direct	Tier 2: Anthem BCBS	Limits / Notes
Lab & minor diagnostics	$40 copay	Ded., then $50 copay	Labs, ultrasound, bone density, echography
Radiology (x-ray)	$50 copay	Ded., then $75 copay	Office/outpatient
Advanced imaging (CT/MRI/PET)	$400 copay	Ded., then $600 copay	Pre-certification required

EMERGENCY & URGENT	Tier 1: Northwell Direct	Tier 2: Anthem BCBS	Limits / Notes
Emergency room	$600 copay	$600 copay	Copay waived if admitted; same out-of-network
ER physician	No charge	No charge	
Ambulance (ground/air)	$600 copay	$600 copay	Emergency only; same out-of-network
Urgent care	$50 copay	$75 copay	

HOSPITAL & SURGERY	Tier 1: Northwell Direct	Tier 2: Anthem BCBS	Limits / Notes
Inpatient facility	$500 copay/admit	Ded., then $1,000 copay/admit	Pre-certification required
Inpatient physician visits	$40 copay	Ded., then $50 copay	
Outpatient surgery (facility)	$500 copay	Ded., then $1,000 copay	Pre-certification required
Surgeon (outpatient)	$500 copay	Ded., then $1,000 copay	In-office surgery: office copay applies
Skilled nursing facility	$500 copay/admit	Ded., then $1,000 copay/admit	Pre-certification required

MATERNITY	Tier 1: Northwell Direct	Tier 2: Anthem BCBS	Limits / Notes
Routine prenatal / postnatal	No charge	No charge	PCP copay applies to first visit only
Delivery — facility	$500 copay/admit	Ded., then $1,000 copay/admit	Pre-cert for stays over 48 hrs (vaginal) / 96 hrs (C-section)
Delivery — professional	$40 copay	Ded., then $50 copay	Newborn claims process under the baby's coverage
Breast pump	No charge	No charge	Electric and manual covered under ACA

MENTAL HEALTH & SUBSTANCE USE	Tier 1: Northwell Direct	Tier 2: Anthem BCBS	Limits / Notes
Office visit	$40 copay	$50 copay	
Outpatient services	$40 copay	Ded., then $50 copay	Includes intensive outpatient
Inpatient / residential	$500 copay/admit	Ded., then $1,000 copay/admit	Pre-certification required
Partial hospitalization	$40 copay	Ded., then $50 copay	Pre-certification required

THERAPIES & OTHER CARE	Tier 1: Northwell Direct	Tier 2: Anthem BCBS	Limits / Notes
PT / OT / Speech therapy	$40 copay	Ded., then $50 copay	50 visits/yr combined; pre-cert required
Chemotherapy	$75 copay	Ded., then $100 copay	
Radiation therapy	$75 copay	Ded., then $100 copay	
Dialysis	$75 copay	Ded., then $100 copay	
Home health care	$40 copay	Ded., then $50 copay	40 visits/yr combined with home infusion; pre-cert
ABA therapy	$40 copay	Ded., then $50 copay	Pre-certification required
Durable medical equipment	$400 copay	Ded., then $500 copay	Pre-cert for items over $1,000
Diabetic equipment & supplies	$400 copay	Ded., then $500 copay	Omnipods covered
Hospice (outpatient)	$500 copay	Ded., then $1,000 copay	Pre-certification required
Children's eyeglass frames/lenses	No charge	No charge	Under age 19 only

MOST COMMON ITEMS NOT COVERED

Routine adult dental and vision care, hearing aids and cochlear implants, bariatric surgery, infertility treatment (diagnosis is covered), acupuncture, private duty nursing, prosthetics and orthotics, gene therapy, elective abortion, cosmetic procedures, weight-loss programs, in-home visits, and non-emergency care when traveling outside the U.S. The full list from the SPD appears on the next page.

Plan Exclusions & Limitations

Condensed from the SPD's exclusion sections — the SPD contains the complete, controlling text.

GENERAL EXCLUSIONS — NO COVERAGE FOR CHARGES ARISING FROM

- Services that are **not Medically Necessary**, are **Experimental or Investigational**, are not accepted as standard practice by the AMA/ADA/FDA, or are **not specified as covered** under the Plan
- Care received **before coverage begins or after it ends**, or while no coverage is in force
- **Cosmetic surgery** — procedures primarily to improve appearance (exceptions: accident repair, infection or illness, and congenital defects of a covered dependent child)
- **Custodial care**, rest cures, maintenance care, and **long-term care**
- **Occupational** injuries and illnesses arising out of employment or self-employment (workers' compensation), and **professional or semi-professional athletics**
- **Hazardous pursuits** — e.g., hang gliding, skydiving, bungee jumping, parasailing, ATVs, explosives, racing, rock climbing, travel to advisory-warning countries
- Injuries from **illegal acts**, activities made illegal by **alcohol or intoxication**, or voluntary use of **illegal drugs** (domestic-violence victims and documented medical conditions excepted; SUD treatment remains covered)
- **War or riot** participation; care during confinement in a **prison or penal institution**
- Services rendered by an **immediate family member** or anyone living in the member's household
- Care that is or could be provided **at government expense** or in government-operated facilities (VA/military exceptions apply as required by law); services with **no legal obligation to pay** or no direct charge
- **Foreign travel** undertaken for the purpose of obtaining medical services, unless approved by the Plan Administrator
- Charges that **exceed the Maximum Allowable Charge** or Plan limits; expenses from unreasonable **provider error** or negligence, as determined by the Plan Administrator
- **Administrative costs** — claim forms, records, reports; **postage, shipping, handling**, interest, and financing charges; charges for **broken appointments**
- **Non-prescription drugs** outside a hospital or inpatient facility, and drugs with a non-prescription equivalent (except as required under ACA Preventive Care)
- **Complications of non-covered services**, unless expressly stated otherwise
- Expenses payable under the Plan's **subrogation, reimbursement, or third-party responsibility** provisions

MEDICAL BENEFIT EXCLUSIONS

- **Abortion** (elective) — covered only where the mother's life is endangered, for medical complications, or for pregnancy from rape or incest
- **Acupuncture** and acupuncture in lieu of anesthetic; **alternative medicine** — holistic, homeopathic, naturopathic, thermography; **biofeedback**; **hypnosis**
- **Allergy treatment** (injections and serum; testing is covered)
- **Dental care** — routine dental, gum treatment, oral surgery involving teeth, dentures, orthodontics (accident-related care to sound natural teeth within 18 months is covered); **wisdom teeth surgery**
- **Vision** — eye refractions, eyeglasses and contacts (except children under 19 and post-cataract), refractive surgery, vision therapy, orthoptic training, orthokeratology
- **Hearing** — hearing aids, exams for fitting them, and implantable hearing devices including cochlear implants
- **Infertility and impregnation treatment** — artificial insemination, IVF, GIFT, fertility drugs, donor eggs/sperm, surrogacy, freezing (diagnosis of infertility is covered)
- **Obesity** — bariatric surgery (gastric bypass, banding, stapling) and weight-loss or dietary-control care (ACA obesity screening and counseling are covered)
- **Genetic counseling or testing** except as covered under Preventive Care; **gene and cellular therapy**
- **Prosthetics and orthotics**, orthopedic shoes, supportive foot devices, and replacement braces (unless medically required by physical change); **foot disorder surgery** and routine foot care
- **Private duty nursing**; **halfway house** services; **in-home visits** outside home health care
- **Injection and infusion procedures** other than chemotherapy (biologics, immunotherapies, vitamin infusions, pain-management injections)
- **Sexual dysfunction** treatment; **male sterilization** and sterilization reversal; **gender-affirming hormone therapy**
- **Sleep studies** (in-lab PSG, home tests, MSLT, MWT); **TMJ** diagnosis and treatment; **osseous surgery**
- **Pregnancy expenses of a dependent child** (preventive care is covered)
- Exams for **insurance, school, licenses**, or employment; **education or training programs**
- **Personal convenience items** (air conditioners, humidifiers, exercise equipment); **hair pieces and wigs**; **vitamins and nutritional supplements** (except preventive/prenatal per ACA); **medical foods** taken orally (except PKU formula)

PRESCRIPTION DRUG EXCLUSIONS & LIMITS

- **Specialty drugs** (retail and mail order)
- **Fertility agents**; **growth hormones**; **impotency medication** (incl. Viagra)
- **Anorexiants** (weight-loss drugs); **anti-aging products**; **anabolic steroids**
- **Experimental and investigational-use** drugs
- **Allergy sera**; **blood and blood plasma**; **Imitrex injections**
- **Over-the-counter drugs** and non-prescription equivalents (except ACA-required items, diabetic supplies, diagnostics)
- **Non-insulin syringes/needles**; medical devices and supplies; drug **administration** charges
- Drugs **consumed where dispensed** or taken while confined in an institution
- **Supply limits:** 30-day retail / 90-day mail order per fill
- **Refills:** only as prescribed, up to 1 year from the order date
- **Participating pharmacies only** — no reimbursement without the ID card or at non-participating pharmacies

Victims of domestic violence or a documented medical condition are not denied otherwise-covered benefits under the alcohol, illegal-acts, or drug-related exclusions. Benefit limits at a glance: chiropractic 30 visits/yr; PT/OT/ST 50 visits/yr combined; home health + home infusion 40 visits/yr combined; hospice requires a life expectancy of 6 months or less with 30-day physician recertification.

Prescription Drug Benefits

Administered by CarelonRX

Drug Tier	Retail (30-day supply)	Mail Order (90-day supply)
Level 1 — Generic	$10 copay	$30 copay
Level 2 — Preferred brand	$50 copay	$150 copay
Level 3 — Non-preferred brand	$80 copay	$240 copay
Injectables	30% coinsurance	—
Specialty drugs	Not covered	Not covered

How the pharmacy benefit works

- **No separate Rx deductible.** Copays start with the first fill.
- **One combined cap.** Prescription copays count toward the same $6,000 / $18,200 out-of-pocket maximum as medical expenses. After the cap, covered drugs are paid at 100%.
- **Participating pharmacies only.** Show the ID card at a participating pharmacy. No reimbursement for non-participating pharmacies or claims filled without the card.
- **Mail order saves money.** Maintenance medications (heart disease, blood pressure, asthma, and similar) can be filled in 90-day supplies at roughly one month's savings per quarter.
- **Covered:** legend drugs, insulin and diabetic supplies, contraceptives (HRSA guidelines), immunizations, EPI pens, compounded prescriptions, prenatal vitamins, smoking-cessation aids.
- **Not covered:** specialty drugs, fertility agents, weight-loss drugs, growth hormones, impotency medication, experimental drugs, anti-aging products, over-the-counter items (except as ACA-required).
- **Rx pre-certification:** certain drugs require pre-certification through Carelon before they are covered.

Drug tiers explained

Generic (Level 1) drugs are therapeutically equivalent to brand names at the lowest cost — pharmacies dispense them automatically when available. **Preferred brand (Level 2)** drugs are brand names with no or limited generic alternatives. **Non-preferred brand (Level 3)** drugs have generic or preferred alternatives available; members pay the highest copay for these.

Pre-Certification & Utilization Management

Reviewed by WellGuide Health, LLC

THE RULE: Pre-certification is required before all non-emergency hospital admissions, mental health or substance-use treatment, and the other services listed below — or within 48 hours of an emergency admission. The pre-certification number is printed on the member ID card. If pre-certification is required but not obtained, the claim will be **denied**. Retrospective review is available within 90 days of the date of service without penalty; after 90 days (within the appeal window) a **50% penalty** applies.

Common services requiring pre-certification

Inpatient	Outpatient / Ambulatory	Ancillary & Other
• All elective admissions • Skilled nursing & rehab facility • Hospice • Transplants • Spine surgeries • OB stays beyond federal minimum • LTAC admissions	• Ambulatory surgery (many procedures) • Advanced imaging (MRI, CT angiography, cardiac MRI, PET) • Cochlear implant • Sleep apnea surgery • Varicose vein treatment • Septoplasty / rhinoplasty	• Home health & home infusion • PT / OT / Speech therapy • Behavioral health: inpatient, RTC, PHP, IOP, TMS, ABA • DME & orthotics over $1,000, wheelchairs, CPAP, insulin pumps • Genetic testing (certain) • Specialty infusion drugs

Partial list — the SPD's Utilization Management section contains the complete inventory. Maternity stays of 48 hours (vaginal) / 96 hours (C-section) are automatically pre-certified.

Emergency admissions

Emergencies never require advance approval — get care immediately. Notify the pre-certification department within **24 hours** of a weekday emergency admission, or within **72 hours** (or the first business day) for admissions after hours on Friday, weekends, or holidays.

Also included in utilization management

Case management — a voluntary, no-penalty program that coordinates care for serious, chronic, or high-cost conditions. **Continued-stay review and discharge planning** happen automatically during hospital confinements. **Pre-surgical review** is recommended for procedures that are often cosmetic (e.g., abdominoplasty, blepharoplasty, breast reduction) to confirm medical necessity before scheduling.

Eligibility & Enrollment

Who can join, when coverage starts, and exactly what paperwork to collect.

Who is eligible

- **Entity requirement:** enrollment is available to employer groups, or to a single-member LLC, C Corporation, S Corporation, or Schedule C sole proprietorship.
- **Employees** are eligible on the first day of the month after their enrollment is received, provided enrollment is received before the 26th of the month. There is no waiting period.
- **Spouses and dependent children** (to age 26; older if disabled and dependent) may be covered once the employee is enrolled. A dependent may only be covered under one employee.
- **Newborns** are covered from birth **only if** a written application is received within 31 days of the date of birth.

When members can enroll

Window	When	Coverage Effective
Initial enrollment	Enrollment received before the 26th of the month	First of the following month
Open enrollment	Annually, before the start of the plan year	January 1
Special enrollment — loss of other coverage	Within 31 days of losing other coverage	Day after loss of coverage
Special enrollment — marriage	Within 31 days of marriage	First of the month after the request is received
Special enrollment — birth / adoption	Within 31 days of the event	Date of birth, adoption, or placement
Medicaid / CHIP events	Within 60 days of losing Medicaid/CHIP or gaining premium assistance	First day after the event

The enrollment packet — three documents

1. Membership Form	2. Personal Health Questionnaire	3. HIPAA Release
Enrollment/membership form: employee and employer information, dependents for medical coverage, and death-benefit beneficiary designation. Signed and dated in three places.	Health Plan Application (PHQ) for the employee and every family member applying: demographics, prior coverage carrier with start/end dates, and the full health history with details for any 'yes' answers. Incomplete or inaccurate answers can delay or jeopardize coverage.	Authorization to obtain and disclose PHI for underwriting and enrollment. **Complete in duplicate** — the member keeps a copy. Valid 30 months; revocable in writing to the plan's Underwriting Department.

Submit completed enrollment packets through your benefits representative. Applications are subject to review and approval; submission does not itself guarantee coverage. A one-time enrollment fee applies: $125, or $250 for groups of 2 or more.

After enrollment: Nuera Benefits Agency handles ongoing account administration — monthly billing (including the $10 monthly administrative fee), eligibility maintenance, and demographic changes such as address updates, dependent additions or removals, and coverage-tier changes. Contact information is provided upon enrollment and approval.

When coverage ends: coverage generally ends on the last day of the month in which employment ends, eligibility is lost, or a required contribution is not made. Dependent coverage ends when the employee's does, or when the dependent no longer qualifies. COBRA continuation rights and details are described in the SPD.

Plan Partners & Quick Answers

Who does what under the plan — complete contact information is provided after enrollment and approval.

Role	Plan Partner
Plan administration, claims, eligibility & benefits	International Benefits Administrators (IBA)
Care navigation & finding providers	Rightway Healthcare Concierge
Pre-certification & utilization review	WellGuide Health
Pharmacy benefits	CarelonRX / Carelon
24/7 virtual care	CirrusMD
Tier 1 provider network	Northwell Direct
Tier 2 provider network	Anthem Blue Cross Blue Shield
Term life insurance ($7,000 benefit)	Prudential
Billing, eligibility & demographic changes	Nuera Benefits Agency

Member ID cards and welcome materials include every phone number, website, and claim-filing address needed to use the plan — provided to each member after enrollment and approval.

Quick answers for common questions

Q: Do I need to pick a primary care physician?
A: No. This is a PPO — no PCP designation and no referrals are required.

Q: What if my doctor isn't in Northwell Direct?
A: Check Tier 2: the Anthem BCBS network covers over 95% of U.S. doctors. The visit simply uses Tier 2 cost sharing.

Q: Does the deductible apply to office visits?
A: No. Office visits, urgent care, preventive care, and telehealth are copay-only in both tiers.

Q: What happens in an emergency away from home?
A: Emergency care is always paid at the network level, anywhere — $600 ER copay, waived if admitted.

Q: Do prescriptions count toward the out-of-pocket max?
A: Yes. Medical and pharmacy costs accumulate to one combined $6,000 individual / $18,200 family cap.

Q: My child was just born — what now?
A: Submit a written application to add the baby within 31 days of birth. Miss the window and the child cannot join until the next open enrollment.

Q: Is a pre-existing condition a problem?
A: The plan imposes no eligibility variations based on health status; the PHQ is used for underwriting the group, and complete, accurate answers protect the member's coverage.

About this guide. Prepared for plan representatives and members. It summarizes the Dual Option Platinum PPO plan using the official Plan Document/SPD, the 2026 Summary of Benefits and Coverage, and 2026 plan materials. It is not a contract and does not alter the Plan. In the event of any conflict, the official Plan Document and Summary Plan Description govern. The Plan is self-funded, non-grandfathered, and governed by ERISA. Possession of an ID card does not guarantee eligibility for benefits.