



Benefit or Service	Member Cost Share	Additional Information
Abortion, Voluntary Termination of Pregnancy	0% coinsurance, no deductible	Includes abortion for which public funding is prohibited.
Acupuncture	\$50.00 copay not subject to the deductible.	Limited to 12 visits per year calendar year. Unlimited visits for chemical dependency treatment, SUD, substance abuse.
Allergy Care	40% coinsurance after deductible	Includes allergy tests, allergy injections and serums. Allergy serum is only covered under this benefit if received and administered at a provider's office.
Ambulance (Emergency Transportation) ground and air	40% after deductible	
Ambulance (Non-Emergency)	NOT COVERED	NOT COVERED



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Anesthesiologist (Anesthesia) (professional)	40% coinsurance after deductible does not include facility fee	For the benefit of dental anesthesia provided in a facility, a child must be under 7 yrs. old or is developmentally delayed or if a physician determines a medical condition places the patient at undo risk if performed in the dentist office. Includes services to prepare the jaw for radiation treatment of neoplastic disease. The Dental anesthesia benefit does not include the charges for the dentist or anesthesia performed in a dentist office.
Applied Behavior Analysis Therapy (ABA)	*2 visits at \$1 copay, after which regular copay applies \$50.00 copay, not subject to the deductible.	*These visits apply to a combination of benefits, Mental Health visit and SUD visit. For example, a mental health visit on one day and SUD visit on a separate day. The two separate visits for these two separate benefits for \$1 copay is now maxed. Prior authorization is required. Must be prescribed. Must be performed by a qualified ABA provider. Must be diagnosis of autism spectrum disorder and meet criteria of the plan.
Birthing Center (Facility)	40% coinsurance after deductible	
Birthing Center Professional midwife/midwives	40% coinsurance after deductible	
Birth in the Home Supplies	40% coinsurance after deductible	



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Birth in the Home Professional midwife/midwives	40% coinsurance after deductible	
Bariatric Surgery	NOT COVERED	NOT COVERED
Bone mass measurement (Bone Density)	\$0 Cost Share	PA Required if more often than once every 2 years.
Breast cancer screening (mammograms, mammography, including 3D mammography)	\$0 Cost Share	The first mammogram per calendar year is covered under preventive care regardless of diagnosis. Subsequent mammograms within in the same year are covered under radiology benefits.
Cardiac rehabilitation services	40% coinsurance after deductible	Coverage for cardiac rehabilitation requires that Members that have experienced a cardiac event such as myocardial infarction, chronic stable angina, heart transplant or heart and lung transplants.
Cervical and vaginal cancer screening (Pap tests, pelvic exams)	\$0 Cost Share	For planned preventive services: <ul style="list-style-type: none"> • All women: Every 24 months • High risk of cervical cancer or abnormal pap: Every 12 months, is not routine care and is subject to cost shares. Diagnostic: 40% after the deductible.
Chemotherapy	40% coinsurance after deductible	



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Chiropractor services	\$50.00 copay deductible does not apply	Limit 10 visits, coverage includes manipulation of the spine and diagnosis and treatment of musculoskeletal disorders, diagnostic radiology, when performed within the scope of the Provider’s license. Radiology has separate cost share.
Clinical Trials	Cost share determined by service, e.g. outpatient hospital copay, specialist visit, etc.	
Colorectal cancer screening (Colonoscopy, Sigmoidoscopy)	\$0 Cost Share	<p>For planned preventive services: For age 45 and older:</p> <ul style="list-style-type: none"> • Sigmoidoscopy every 48 months • Fecal occult blood test, every 12 months <p>For at high risk of colon cancer:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 24 months <p>Not at high risk of colon cancer:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months) but not within 48 months (2 years) of a screening sigmoidoscopy. <p>Diagnostic 20% after the deductible</p>
Cosmetic surgery or procedures	NOT COVERED	NOT COVERED



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Custodial Care	NOT COVERED	Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps with activities of daily living, such as bathing or dressing. Custodial care is not <i>medically necessary</i> .
Deductible, Individual	\$6000.00 includes any Rx subject to the deductible for in network providers.	
Deductible, Family	\$12000.00 includes any Rx subject to the deductible for in network providers.	
Dental Medical Services (Not Routine Dental), Oral Surgery (includes related services e.g. Surgeon, Anesthesia) etc.)	40% coinsurance after deductible	Refer to prior authorization list. Covered services limited to surgery of the jaw or related structures Examples: - setting fractures of the jaw or facial bones - extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease - excision of lesions, cysts and tumors of the jaw, mouth, lip or tongue
Dental Services, Routine Dental, Orthodontia	NOT COVERED	NOT COVERED
Depression screening	\$0 Cost Share	



Benefit or Service	Member Cost Share	Additional Information
Diabetic Education and Diabetic Nutrition Education	\$0 Cost Share	Must be ordered by a provider. Must be performed through authorized outpatient diabetes education facilities. Includes diabetes education, diabetes self-management training and nutritional counseling services.
Diabetic services and diabetes supplies (DME)	40% coinsurance after deductible	PA Required if purchase is \$500.00 or more or rental is \$200.00 per month or more <ul style="list-style-type: none"> • The Durable Medical Equipment (DME) benefit only covers insulin pumps and insulin infusion devices and supplies related to this equipment. •The Pharmacy Benefit covers, insulin, oral hypoglycemic agents, blood glucose monitors, insulin syringes with needles, blood glucose test strips, urine test strips, ketone test strips, ketone tablets, lancets and lancet devices.
Dialysis, Kidney dialysis	40% coinsurance after deductible	
Durable medical equipment (DME) and medical supplies. Includes prosthetic devices.	40% coinsurance after deductible	Refer to current Prior Authorization list for current requirements. PA Required if purchase is \$500.00 or more or rental is \$200.00 per month or more.
Emergency care (ER Physician)	40% coinsurance after deductible	Out of network same as in-network cost shares.



Benefit or Service	Member Cost Share	Additional Information
Emergency Room, ER (facility)	40% coinsurance after deductible	<ul style="list-style-type: none"> • Professional fees are separate from the facility fees. • Copay waived if admitted as inpatient within 24 hours of ER visit. • Includes Medically Necessary detoxification services, including Chemical Dependency detoxification. • Prescription medications associated with a Medical Emergency, including those purchased in a foreign country, are also covered. • Out of network same as in network cost shares.
Enteral Feedings, Tube Feedings, PKU	40% coinsurance after deductible	
Enteral Formula, Nutritional and Dietary Formulas	40% coinsurance after deductible	<p>Coverage for nutritional and dietary formulas, including elemental formulas, and medical foods, is provided when Medically Necessary. The following conditions must be met:</p> <ul style="list-style-type: none"> • The formula is a specialized formula for treatment of a recognized life-threatening metabolic deficiency such as phenylketonuria; or • The formula is the significant source of a patient’s primary nutrition or is administered in conjunction with intravenous nutrition.
Eye exam - Medical (medical vision disease)	<p>Diabetic Retinal Exam - \$0 cost share</p> <p>40% coinsurance after deductible</p>	<p>Covered, Exams to diagnose diseases and conditions of the eye.</p> <p>Not covered, Orthoptics or vision training and any associated supplemental testing.</p>



Benefit or Service	Member Cost Share	Additional Information
Eye exam - Routine Vision (VSP) Children, Up to 19 years of age (Pediatric Vision) Age 19 and over Not covered	Must be VSP network. Out of Network is not covered. \$0 Cost share.	Once per calendar year.
Eye Wear - Medical Vision Hardware	40% coinsurance after deductible	Covered under DME for the following conditions of the eye: - Corneal ulcer - bullous keratopathy - recurrent erosion of cornea - tear film insufficiency - aphakia - Sjorgren’s disease - Congenital cataract - Corneal abrasion - Keratoconus



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<p>Eye Wear - Routine Vision Hardware (VSP) Children, Up to 19 years of age (Pediatric Vision)</p> <p>AGE 19 and OVER NOT COVERED</p> <p>Prescription Contacts, frames, vision lenses, upgrades, glasses</p>	<p>Must be VSP network. Out of Network is not covered.</p> <ul style="list-style-type: none"> • Frames: \$0 cost share. • Spectacle Lenses: \$0 cost share. • Contact Lenses In lieu of lenses and frames. \$0 cost share. 	<p>FRAMES:</p> <ul style="list-style-type: none"> • Once per calendar year. Frames from the Otis & Piper Eyewear Collection. Includes fitting fee. • Repair of glasses or replacement of lost or stolen glasses is not covered. <p>SPECTACLE LENSES:</p> <ul style="list-style-type: none"> • Once per calendar year. Includes impact-resistant plastic or glass lenses, scratch resistant coating and ultraviolet coating. • Lens Enhancements: Member elected non-covered enhancements are member responsibility. Members save an average of 20-25%. <p>CONTACT LENSES IN LIEU OF LENSES AND FRAMES:</p> <ul style="list-style-type: none"> • Once per calendar year. Includes fitting fees. • Standard lenses (one pair, 1 contact lens per eye, total 2 lenses) per year. • Monthly lenses (six month supply, 6 lenses per eye, total 12 lenses,) per year • Bi-weekly lenses (three month supply, 90 lenses per eye, total 180 lenses) per year • Dailies (three month supply, one year supply)



Benefit or Service	Member Cost Share	Additional Information
Eye and Vision Routine Services Not Covered	N/A	Eyeglasses or contact lenses for conditions not listed under medical eye wear, vision hardware or covered under the Pediatric Vision benefit.
Family Planning, contraception, birth control	\$0 Cost Share	<p>FDA-approved contraceptive services provided in the office or outpatient setting, includes IUDs, subdermal implants, including the insertion and removal, and voluntary sterilization procedures, including vasectomy and tubal ligation with no Cost-Sharing when provided by Network Providers.</p> <ul style="list-style-type: none"> • Contraceptive methods that require a prescription, including oral contraceptives, transdermal patches, the vaginal ring, Medroxyprogesterone injections and emergency contraceptives, are covered under the Prescription Drug benefit. • FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides, are covered under the Prescription Drug benefit only when prescribed by a qualified Provider.



Benefit or Service	Member Cost Share	Additional Information
Genetic Testing, includes prenatal testing for congenital disorders	40% coinsurance after deductible	Prior Authorization may be required. <ul style="list-style-type: none"> • One copay when technical component and professional component are performed by the same provider. • Separate cost shares when the components are performed by separate providers. • Not covered, genetic tests of a child's father as a part of prenatal or newborn care.
Habilitative Inpatient	40% coinsurance after deductible	Limit of 30 Days Per Calendar Year All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.
Habilitative Outpatient	40% coinsurance after deductible	25 combined visit limit per calendar year. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 25 visits.
Hearing exam (Medical)	40% coinsurance after deductible	Routine hearing exams for hearing loss, hearing aids, and hearing aid fittings are not covered.
Hearing exam (Routine)	NOT COVERED	NOT COVERED
Hearing services (hearing aid fittings, hearing aids)	NOT COVERED	NOT COVERED



Benefit or Service	Member Cost Share	Additional Information
Hearing services, Cochlear Implants	40% coinsurance after deductible for DME	The following conditions must be met: - Services are to keep, restore and significantly improve function that was previously present but lost or impaired due to Disability, Injury or Illness; - Services are not for palliative, recreational, relaxation or maintenance therapy; and - Loss of function was not the result of a work-related Injury.
HIV screening	\$0 Cost Share	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
HIV PrEP	\$0 Cost Share	Pre-exposure prophylaxis (PrEP) covered for people at high risk of HIV infection.



Benefit or Service	Member Cost Share	Additional Information
Home health agency care	\$50.00 copay not subject to the deductible.	<p>130 Visits per year limit</p> <ul style="list-style-type: none"> • Pre-Authorization is required for home health care benefits. The patient must be homebound and require Skilled Care services. Home health care is covered when provided as an alternative to hospitalization and prescribed by a physician. • Covers Home infusion Therapy • Home health care listed below is not covered: <ul style="list-style-type: none"> - Custodial Care; - Private duty nursing; - Housekeeping or meal services; - Maintenance care; or - Shift or hourly care services. <p>40% coinsurance for durable medical equipment (DME) also applies when related to Home Health services.</p>



Benefit or Service	Member Cost Share	Additional Information
Hospice care	Cost share determined be where services are performed. Inpatient Hospital copays or Home \$50.00 copay not subject to the deductible.	Hospice care listed below is not covered: <ul style="list-style-type: none"> - Custodial Care or maintenance care, except palliative care to the terminally ill patient - Financial or legal counseling services; - Housekeeping or meal services; - Services by a Subscriber or the patient’s Family or Volunteers; - Services not specifically listed as covered hospice services under this plan; - Supportive equipment such as handrails or ramps; or - Transportation.
Hospice Respite Care	\$50.00 copay not subject to the deductible.	14 Days per year
Hyperbaric oxygen treatment	40% coinsurance after deductible	
Immunizations	\$0 Cost Share	Immunizations administered by pharmacists must be billed as a professional claim (HCFA form).



Benefit or Service	Member Cost Share	Additional Information
Infertility Diagnostic Services	40% coinsurance after deductible for, anesthesia, etc.	<p>Pre-Authorization is required for services provided in an inpatient setting.</p> <p>Coverage is provided for only the initial evaluation and diagnosis of infertility. Examples of Covered Services for the initial diagnosis of infertility include: endometrial biopsy, hysterosalpingography, reproductive screening services, or sperm count.</p> <p>Not covered:</p> <p>Treatments and procedures for the purposes of producing a pregnancy are not covered.</p>
Infusion Therapy	40% coinsurance after deductible	<p>PA Required if provided in home or freestanding infusion site</p> <p>Cost share is based on place of service. See cost shares for outpatient facility and professional charges.</p>
Injections, Injectable drugs	40% coinsurance after deductible	<p>See Prior Authorization (PA) List</p> <p>Note: All Unclassified biologics (J3590) require a prior authorization.</p> <p>Drugs that are administered under the supervision of physician, through home infusion or within a medical facility. Includes chemotherapy related drugs, drugs related to home dialysis, B12, etc. Self injectable drugs are covered under the pharmacy benefit.</p>



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Inpatient hospital Blood (including inpatient skilled nursing facility/SNF)	40% coinsurance after deductible	
Outpatient Blood	40% after deductible.	
Inpatient hospital (acute) care	40% after deductible.	All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.
Inpatient Professional Services including SNF	40% after deductible.	
Inpatient Hospital mental health, psychiatric, psychiatrist-care (facility)	40% after deductible.	All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.
Inpatient rehabilitation (facility)	40% after deductible.	30 Days Per Calendar Year All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.
Inpatient substance disuse, SUD, chemical dependency (facility)	40% after deductible.	Prior authorization. Also applies to residential treatment.
Mastectomy related bras and supplies (DME)	40% after deductible.	



Benefit or Service	Member Cost Share	Additional Information
<p>Nutritional Counseling</p>	<p>*2 visits at \$1 copay, after which regular copay applies</p> <p>\$50.00 copay, deductible does not apply.</p>	<p>*These visits apply to a combination of benefits, PCP visit and Nutritional Counseling Visit and Prenatal Congenital Anomalies Office Visit. For example, a PCP on one day and Nutritional Counseling on separate day. The two separate visits for these two separate benefits for \$1 copay is now maxed.</p> <p>Does not apply to diabetics. See Diabetic Education and Diabetic Nutrition Education for additional information.</p>
<p>Nurse Advice Line</p>	<p>0% cost share</p>	<p>24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006</p>



Benefit or Service	Member Cost Share	Additional Information
<p>Obesity counseling, Weight Loss and Weight Management</p>	<p>40% after deductible.</p>	<p>Weight loss and weight management therapies are covered for children aged 6 and older who qualify as obese and adult members and children age 6 and older with a documented body mass index (BMI) of 30 kg/m² or higher, when provided by an In-Network provider. The following multicomponent behavioral interventions are covered by the plan:</p> <ul style="list-style-type: none"> •High intensity group and individual counseling sessions (12-26 sessions within a year), •Behavioral management activities, such as weight-loss goals, •Improving diet or nutrition and increasing physical activity, •Addressing barriers to change, •Self-monitoring, and •Strategizing how to maintain lifestyle changes. <p>Not covered by this plan:</p> <ul style="list-style-type: none"> •Exercise programs or use of exercise equipment, •Weight-loss diet supplements, such as Optifast liquid protein meals, NutriSystems pre-packaged foods, Medifast foods, phytotherapy, •Jenny Craig, Weight Watchers, Diet Center, Zone diet or other similar programs. •Bariatric Surgery
<p>Organ (Living, Donor) Donation (Transplant)</p>	<p>40% after deductible.</p>	<p>All admissions, planned and urgent, require notification within 24 hrs. or next business day.</p>



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MOOP Out of Pocket Max. Per Year, Individual, includes pharmacy	\$9200, includes copays including pharmacy and all services applied to deductibles for in-network services.	
MOOP, Out of Pocket Max. Per Year, Family, includes pharmacy	\$18,400, includes copays including pharmacy and all services applied to deductibles for in-network services.	
Orthotics	40% coinsurance after deductible	This benefit does not cover off-the-shelf shoe inserts or orthopedic shoes.
Lab and Pathology	40% coinsurance after deductible	<ul style="list-style-type: none"> • One copay when technical component and professional component are performed by the same provider. • Separate cost shares when the components are performed by separate providers.
X-ray and Radiology (does not include scans)	40% coinsurance after deductible	<ul style="list-style-type: none"> • One copay when technical component and professional component are performed by the same provider. • Separate cost shares when the components are performed by separate providers.
Outpatient diagnostic, Complex imaging, scans, includes, MRI, CT scan, PET scan	40% coinsurance after deductible	



Benefit or Service	Member Cost Share	Additional Information
Outpatient hospital (facility)	40% coinsurance after deductible	<ul style="list-style-type: none"> • Prior Authorization is required for certain outpatient surgery/procedures. Refer to the PA list on CHPW.org • Professional fees are separate from the facility fees.
Outpatient Professional	See specialist.	
Outpatient Surgeon and Asst. Surgeon , Midwife/midwives	40% coinsurance after deductible	
Mental health visits outpatient (professional)	*2 visits at \$1 copay, after which regular copay applies \$50.00 copay, not subject to the deductible.	*These visits apply to a combination of benefits, Mental Health visit and SUD visit. For example, a mental health visit on one day and SUD visit on a separate day. The two separate visits for these two separate benefits for \$1 copay is now maxed.
Outpatient rehabilitation services (physical (PT), speech (ST), occupational therapy (OT)	40% coinsurance after deductible	25 combined visit limit per calendar year. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 25 visits.



Benefit or Service	Member Cost Share	Additional Information
<p>Outpatient substance disuse, SUD, chemical dependency visits (professional)</p>	<p>*2 visits at \$1 copay, after which regular copay applies \$50.00 copay for E & M service, deductible does not apply. Other services 40% coinsurance after the deductible</p>	<p>*These visits apply to a combination of benefits, Mental Health visit and SUD visit. For example, a mental health visit on one day and SUD visit on a separate day. The two separate visits for these two separate benefits for \$1 copay is now maxed.</p> <p>Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.</p>
<p>Spinal Manipulations</p>	<p>40% coinsurance after deductible</p>	<p>See separate benefit for Chiropractors.</p>
<p>Surgery, ambulatory surgical centers (ASC)</p>	<p>40% coinsurance after deductible</p>	<ul style="list-style-type: none"> • Prior Authorization is required for certain outpatient surgery/procedures. Refer to the PA list on CHPW.org • Professional fees are separate from the facility fees.
<p>Over the Counter (OTC) medication/pharmacy</p>	<p>NOT COVERED except FDA approved, FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides. OTC Covid Tests are not covered. See Pharmacy.</p>	



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<p>Partial hospitalization service intensive outpatient mental health services (facility)</p>	<p>*2 visits at \$1 copay, after which regular copay applies \$50.00 copay for E & M service, deductible does not apply. Other services 40% coinsurance after the deductible</p>	<p>*These visits apply to a combination of benefits, Mental Health visit and SUD visit. For example, a mental health visit on one day and SUD visit on a separate day. The two separate visits for these two separate benefits for \$1 copay is now maxed.</p>
<p>Outpatient substance disuse, SUD, chemical dependency (facility)</p>	<p>*2 visits at \$1 copay, after which regular copay applies \$50.00 copay for E & M service, deductible does not apply. Other services 40% coinsurance after the deductible</p>	<p>*These visits apply to a combination of benefits, Mental Health visit and SUD visit. For example, a mental health visit on one day and SUD visit on a separate day. The two separate visits for these two separate benefits for \$1 copay is now maxed.</p> <p>Includes outpatient treatment in outpatient hospital, outpatient treatment center, and partial hospitalization or an intensive outpatient program.</p>
<p>Physical Exam, Periodic Exam, Annual Exam, Screenings, Preventive</p>	<p>\$0 Cost Share</p>	



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<p>Primary Care Physician (PCP) office visits</p>	<p>*2 visits at \$1 copay, after which regular copay applies \$50.00 copay for E & M service, deductible does not apply. Other services 40% coinsurance after the deductible</p>	<p>*These visits apply to a combination of benefits, PCP visit and Nutritional Counseling Visit and Prenatal Congenital Anomalies Office Visit. For example, a PCP on one day and Nutritional Counseling on separate day. The two separate visits for these two separate benefits for \$1 is now maxed.</p> <ul style="list-style-type: none"> • Services can be performed by a naturopath, nurse practitioner or physician assistant. • Copay applies to E & M (visit) only • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply
<p>Podiatry Services (Routine Foot Care)</p>	<p>DIABETICS ONLY</p>	<p>Routine foot care is only covered for diabetics. \$0 Cost Share</p>
<p>Podiatry Services (Foot Care) Medical Covered</p>	<p>40% after deductible \$0 Cost share for diabetics</p>	



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Prescription drugs, pharmacy	<ul style="list-style-type: none"> • Not subject to the deductible: <ul style="list-style-type: none"> o Asthma inhalers/ epinephrine auto injectors/EpiPen -\$35.00, 30-day Supply o Insulin, \$35, 30-day supply o Generic, \$32, 30-day o Generic, \$86, 90-day supply • After deductible: <ul style="list-style-type: none"> o Preferred, 40% coinsurance o Non-Preferred, 40% coinsurance o Specialty Rx 40% coinsurance 	<ul style="list-style-type: none"> • Immunizations administered by pharmacists in a pharmacy must be submitted as a professional claim (HCFA). • Not covered: Over the counter (OTC) except FDA approved, FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides. • OTC Covid Tests are not covered.
Prostate cancer screening exams (PSA)	\$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. For men over age 50: <ul style="list-style-type: none"> • Every 12 months: Digital rectal exam • Every 12 months PSA test
Prosthetic devices and related supplies	40% coinsurance after deductible	Prosthetic/Orthopedic Shoes that are part of a leg brace are covered and included in the cost of the leg brace.



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Pulmonary rehabilitation services	40% coinsurance after deductible	*Refer to prior authorization list.* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.
Reconstructive Surgery	40% after deductible	Covered because of an accidental injury or to improve a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	\$0 copay	



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<p>Skilled nursing inpatient facility (SNF) care</p>	<p>40% coinsurance after deductible</p>	<p>Coverage is limited to 60 inpatient days per year Requires Pre-Authorization.</p> <ul style="list-style-type: none"> • Nursing Facility services are covered when provided as an alternative to hospitalization and prescribed by your Provider. • Room and board is limited to a semi-private room, except when a private room is determined to be Medically Necessary. • Care must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome, including services provided by a licensed behavioral health Provider for a covered diagnosis. <p>Not Covered: Maintenance and Custodial Care are not covered.</p>
<p>Smoking and tobacco use cessation</p>	<p>0% Coinsurance with Alere Or 40% Coinsurance other providers</p>	<p>0% Coinsurance with through Alere Quit-for-Life smoking cessation program. 40% Coinsurance if not Alere Quit-for-Life smoking cessation program</p>
<p>Sterilization Reversal</p>	<p>Not Covered</p>	<p>Not Covered reversal of surgical sterilization, including any direct or indirect complications thereof.</p>



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Specialist Visit	<p>\$100.00 copay after deductible for E & M service</p> <p>Other services 40% coinsurance</p>	<ul style="list-style-type: none"> • Copay applies to E & M (visit) only • Separate copay for facility clinic visit • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply • DOES NOT APPLY TO THE FOLLOWING, SEE RELATED BENEFIT IN THIS GRID: <ul style="list-style-type: none"> • Inpatient professional services. See Inpatient Professional Services • Other Practitioner' Naturopath, nurse practitioner or physician assistant. • Mental Health outpatient, Psychiatrists, mental health. • Substance Use Disorder, SUD. • Prenatal Congenital Anomalies Office Visits. See 'Prenatal Congenital Anomalies Office Visits in this grid.
Telemedicine, Telehealth (Virtual care)	Professional cost shares same as in person visits. Other services 40% after deductible.	
Transplant Evaluation/Work-Up	40% coinsurance after deductible	
Transplant	40% coinsurance after deductible	Corneal transplant does not require prior authorization (PA), other transplants do require PA. All admissions, planned and urgent, require notification within 24 hrs. or next business day.



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Transportation Non-emergency	Not covered	For emergency see Ambulance
Unlisted Codes with Charge Greater Than \$250.00		Unlisted codes is the actual, AMA description of the service. Medical necessity documentation and pricing must be submitted with the request. Example: 43499, Unlisted procedure, esophagus.
Urgently, Urgent needed care, in area, Participating and Non-participating providers	\$100.00 E & M Copay Not Subject to the deductible. Other services 40% afer deductible.	Out-of-area, urgent care is not covered. Out-of-area care is covered under the Emergency Care (ER) benefit and subject to the Emergency Care coinsurance.
Wig (Covered under DME)	40% coinsurance after deductible	Prior Authorization required if purchase exceeds \$500.00. Must be medically necessary.
Lung Cancer Screening	\$0 Cost Share	Limited to ages 55 through 80, once per year.
Out-of-Area, Emergency Care Only	40% coinsurance after deductible for out of network, out of area.	Cost share same as in network. Emergency Room copay waived if admitted inpatient within 24 hours.
Temporomandibular Joint Disorders, TMJ	Cost share determined by service, e.g. outpatient hospital copay, specialist visit, surgery, etc.	
Maternity, OB Care, Prenatal, Postnatal, pregnancy	40% not subject to the deductible	



Benefit or Service	Member Cost Share	Additional Information
Well Baby (Newborn), preventive	\$0 Cost Share	
Radiation	40% coinsurance after deductible	
Transgender Treatment and Surgery, Gender Affirming Care	Cost share determined by service, e.g. outpatient hospital copay, specialist visit, etc.	Gender Affirming Care includes health care services prescribed to treat any condition related to gender identity, e.g. PCP visits, specialty care Rx, surgical services, etc.
Massage Therapy	Not Covered	
Other Practitioner, includes naturopath, nurse practitioner or physician assistant (when not PCP)	*2 visits at \$1 copay, after which regular copay applies \$50.00 copay for E & M service, deductible does not apply. Other services 40% coinsurance after the deductible	<ul style="list-style-type: none"> • Copay applies to E & M (visit) only • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply
Gender Affirming Care	Cost share determined by related service, e.g. PCP visit, outpatient hospital copay, specialist visit, surgery, etc.	Gender Affirming Care includes health care services prescribed to treat any condition related to gender identity, e.g. PCP visits, specialty care Rx, surgical services, etc.
Breast Pump and Related Supplies (DME)	No cost shares	All DME with a purchase price greater than \$500.00 or rental of \$200.00 per month allowed amount requires prior authorization.



Benefit or Service	Member Cost Share	Additional Information
<p>Prenatal Congenital Anomalies Office Visits</p>	<p>*2 visits at \$1 copay, after which regular copay applies \$50.00 copay for E & M service, not subject to the deductible. Other services 40% coinsurance after the deductible.</p>	<p>*These visits apply to a combination of benefits, PCP visit and Nutritional Counseling Visit and Prenatal Congenital Anomalies Office Visit. For example, a PCP on one day and Nutritional Counseling on separate day. The two separate visits for these two separate benefits for \$1 is now maxed.</p> <ul style="list-style-type: none"> • Copay applies to E & M (visit) only • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply
<p>Sleep Studies</p>	<p>40% coinsurance after deductible</p>	<p>Refer to prior authorization list.</p>