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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. Cost shares determined by the service. Prior Authorization is required for services provided in an inpatient setting.
Acupuncture	$15.00 copay not subject to the deductible	Not limited to any condition/diagnosis.
Allergy Care	*$40 copay for E &M service not subject to the deductible. *Allergy tests/lab separate cost share.	Includes allergy tests, allergy injections and serums. Allergy serum is only covered under this benefit if received and administered at a providers office.
Ambulance (Emergency Transportation) ground and air	$375.00 copay not subject to the deductible	
Ambulance (Non-Emergency)	NOT COVERED	NOT COVERED
Anesthesiologist (Anesthesia) (professional)	20% 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 oris 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.

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Benefit or Service	Member Cost Share	Additional Information
Applied Behavior Analysis Therapy (ABA)	$15.00 copay not subject to the deductible	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)	$350.00 Copay after deductible	
Birthing Center Professional, including midwife/midwives	$75.00 after the deductible. Other services 20% after deductible	
Birth in the Home Supplies	20% after the deductible	
Birth in the Home Professional, including midwife/midwives	$75.00 after the deductible. Other services 20% 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.

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Benefit or Service	Member Cost Share	Additional Information
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 lab and radiology benefits and cost shares will apply.
Cardiac rehabilitation services	20% coinsurance after deductible	Coverage for cardiac rehabilitation requires that Members 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: • 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:20% after the deductible.
Chemotherapy	20% coinsurance after deductible	
Chiropractor services (spinal manipulation)	$15.00 copay not subject to the deductible *Applies to Chiropractors only. Other providers e.g. D.O. 20% after deductible, not subject to the 10 visit limit.*	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 coinsurance, specialist visit, etc.	Prior authorization is required and submit clinical trial number.

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Benefit or Service	Member Cost Share	Additional Information
Colorectal cancer screening (Colonoscopy, Sigmoidoscopy)	$0 Cost Share	For planned preventive services: For age 45 and older: • Sigmoidoscopy every 48 months • Fecal occult blood test, every 12 months For at high risk of colon cancer: • Screening colonoscopy every 24 months Not at high risk of colon cancer: • Screening colonoscopy every 10 years (120 months) but not within 48 months (2 years) of a screening sigmoidoscopy. Diagnostic 20% after the deductible
Cosmetic surgery or procedures	NOT COVERED	NOT COVERED
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 *medically necessary.*
Deductible,Individual	$1000.00 includes any Rx subject to deductible for in network providers.	
Deductible,Family	$2000.00 includes any Rx subject to the deductible for in network providers.	

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Benefit or Service	Member Cost Share	Additional Information
Dental Medical Services (Not Routine Dental), Oral Surgery	Cost shares determined by the service. • Inpatient Surgery 20% after deductible • Inpatient hospital copay if applies • Outpatient Surgeon $75.00 copay after deductible • Outpatient facility cost share if applies • Anesthesia 20% coinsurance after deductible • Other 20% 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	
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.

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Benefit or Service	Member Cost Share	Additional Information
Diabetic services and diabetes supplies (DME)	20% coinsurance after deductible	PA Required if purchase is $500.00 or more or rental is $200.00 per month or more • 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	20% coinsurance after deductible	
Durable medical equipment (DME) and medical supplies. Includes prosthetic devices.	20% coinsurance after deductible	Refer to Prior Authorization list for current requirements. All DME with a purchase price greater than $500.00 or rental of $200.00 per month allowed amount requires prior authorization.
Emergency Room, ER, Facility Out of Area,	$450.00 copay after deductible for out of network, out of area. Copay cannot exceed the actual cost of the service. For example if the service is $150.00 the copay will be $150.00.	Emergency Care Out of network, same as in-network cost shares. Professional fees and other services are separate from the facility fees, the 20% coinsurance subject to deductible or other copays may apply. Emergency Room copay waived if admitted inpatient within 24 hours.
Emergency care (ER Physician)	20% after deductible	Emergency Care Only. Out of network same as in-network cost shares.

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Benefit or Service	Member Cost Share	Additional Information
Emergency Room, ER (facility)	$450.00 copay after deductible. Copay cannot exceed the actual cost of the service. For example if the service is $150.00 the copay will be $150.00.	• Professional fees and other services are separate from the facility fees, the 20% coinsurance subject to deductible or other copays may apply. • 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.
Enteral Feedings, Tube Feedings,PKU	20% coinsurance after deductible	Refer to prior authorization list.
Enteral Formula, Nutritional and Dietary Formulas,PKU	20% coinsurance after deductible	Refer to prior authorization list. Coverage for nutritional and dietary formulas, including elemental formulas, and medical foods, is provided when Medically Necessary. The following conditions must be met: • 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)	Diabetic Retinal Exam - $0 cost share 20% coinsurance after deductible	Covered, Exams to diagnose diseases and conditions of the eye. Not covered, Orthoptics or vision training and any associated supplemental testing.

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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	20% coinsurance after deductible	Covered under DME for the following conditions of theeye: - Corneal ulcer - bullous keratopathy - recurrent erosion of cornea - tear film insufficiency - aphakia - Sjorgren's disease - Congenital cataract - Corneal abrasion - Keratoconus

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Benefit or Service	Member Cost Share	Additional Information
Eye Wear - Routine Vision Hardware (VSP) Children, Up to 19 years of age (Pediatric Vision) Age 19 and over Not covered Prescription Contacts, frames,vision lenses,upgrades, glasses	Must be VSP network. Out of Network is not covered. •Frames: $0 cost share. •Spectacle Lenses: $0 cost share. •Contact Lenses In lieu of lenses and frames. $0 cost share.	FRAMES: • 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. SPECTACLE LENSES: • 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%. CONTACT LENSES IN LIEU OF LENSES AND FRAMES: • 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)
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.

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Benefit or Service	Member Cost Share	Additional Information
Family Planning, contraception, birth control	$0 Cost Share	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. • 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.
Genetic Testing, includes prenatal testing for congenital disorders	$20.00 copay	Refer to prior authorization list. • Not covered, genetic tests of a child's father as a part of prenatal or newborn care. • One copay when technical component and professional component are performed by the same provider. • Separate copays when the components are performed by separate providers.
Habilitative Inpatient	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay. Not subject to the deductible. $0 Cost Shares for professional services when Habilitative Inpatient.	Refer to prior authorization list. 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.

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Benefit or Service	Member Cost Share	Additional Information
Habilitative Outpatient	$25.00 copay not subject to the deductible	25 combined visit limit per calendar year. Limit does not apply to these services with a behavioral health (mental health) diagnosis. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 25 visits.
Hearing exam (Medical)	20% coinsurance after deductible	
Hearing exam (Routine)	$15.00	Annual hearing exam
Hearing services, instruments, hearing aids, hearing aid fittings	20% coinsurance not subject to the deductible.	Coverage is limited to one hearing aid per ear every 3 years. Cochlear Implants are also covered.
Hearing services, Cochlear Implants	Cost share determined by service: Outpatient Surgeon $75.00 copay, facility charges if applicable, 20% coinsurance after deductible for DME (implants), anesthesia, etc.	* Covered for adults and children. 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.

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Benefit or Service	Member Cost Share	Additional Information
Home health agency care	$15.00 copay not subject to the deductible	Refer to prior authorization list. 130 Visits per year limit • Covers Home infusion Therapy • Home health care listed below is not covered: - Custodial Care; - Private duty nursing; - Housekeeping or meal services; - Maintenance care; or - Shift or hourly care services. 30% coinsurance for durable medical equipment (DME) also applies when related to Home Health services.
Hospice care	Cost share determined be where services are performed. Inpatient Hospital copays or Home $15.00 copay not subject to the deductible.	Refer to prior authorization list. Hospice care listed below is not covered: - 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	$15.00 copay not subject to the deductible	Refer to prior authorization list. 14 Days per year
Hyperbaric oxygen treatment	20% coinsurance after deductible	Refer to prior authorization list.

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Benefit or Service	Member Cost Share	Additional Information
Immunizations	$0 Cost Share	Immunizations administered by pharmacists must be billed as a professional claim (HCFA form).
Infertility Diagnostic Services and Treatment Services	Cost share determined by service: Surgeon, facility charges if applicable, 20% coinsurance after deductible for, anesthesia, etc.	*Pre-Authorization is required for services provided in an inpatient setting. *Coverage is provided for 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. *Artificial insemination procedures are covered. *Not covered. Surrogacy, surrogate mother, surrogate pregnancy, an assisted reproduction process, resulting in pregnancy of a child intended for other parents
Infusion Therapy	20% coinsurance after deductible	PA Required if provided in home or feestanding infusion site Cost share is based on place of service. See cost shares for outpatient facility and professional charges.
Injections, Injectable drugs	20% after deductible.	• Refer to prior authorization list. • All Unclassified biologics (J3590) require a prior authorization. • 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.
Inpatient hospital Blood (including inpatient skilled nursing facility/SNF)	20% coinsurance after deductible	Refer to prior authorization list. 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.

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Benefit or Service	Member Cost Share	Additional Information
Outpatient Blood	20% coinsurance after deductible	
Inpatient hospital Facility (acute) care	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay. Not subject to the deductible. $0 Cost Shares for professional services when Habilitative Inpatient.	Refer to prior authorization list. 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 Physician and Surgical services (surgeon, asst. surgeon, radiologist, pathologist)including SNF	0% cost share	
Inpatient Hospital mental health, psychiatric, psychiatrist care (facility)	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay. Not subject to the deductible. $0 Cost Shares for professional services when Psychiatric Inpatient.	Refer to prior authorization list. 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.

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Benefit or Service	Member Cost Share	Additional Information
Inpatient rehabilitation (facility)	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay. Not subject to the deductible. $0 Cost Shares for professional services when Inpatient Rehabilitation.	Refer to prior authorization list. 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)	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay. Not subject to the deductible. $0 Cost Shares for professional services when Inpatient SUD.	Refer to prior authorization list. Same cost shares applies to residential treatment.
Mastectomy related bras and supplies (DME)	20% cost share after the deductible	
Nutritional Counseling	$0	Not limited to any condition/diagnosis.
Nurse Advice Line	0% cost share	24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006

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Benefit or Service	Member Cost Share	Additional Information
Obesity counseling, Weight Loss and Weight Management	20% coinsurance after deductible	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: •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. NOT COVERED BY THE PLAN: •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
Organ (Living, Donor) Donation (Transplant)	Cost share determined by service: Inpatient hospital copays, anesthesia, etc.	Refer to prior authorization list. 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.
Out of Pocket Max. Per Year, MOOP, Individual, includes pharmacy	$7000.00, includes copays including pharmacy and all services applied to deductibles for in-network services.	

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Benefit or Service	Member Cost Share	Additional Information
Out of Pocket Max. Per Year, MOOP, Family, includes pharmacy	$14,000.00, includes all copays including pharmacy and all services applied to deductibles for in-network services.	
Orthotics	20% coinsurance after deductible	Refer to prior authorization list. This benefit does not cover off-the-shelf shoe inserts or orthopedic shoes.
Lab, Tests and Pathology	$20.00 copay Not subject to the deductible. Genetic Tests - See Genetic Testing.	Refer to prior authorization list. • One copay when technical component and professional component are performed by the same provider. • Separate copays when the components are performed by separate providers. • No separate professional pathology copay when inpatient
X-ray, Radiology (does not include scans, advanced imaging)	$30.00 Copay Not Subject to the deductible	• One copay when technical component and professional component are performed by the same provider. • Separate copays when the components are performed by separate providers. • No separate professional radiologist copay when inpatient
Outpatient diagnostic, Complex imaging,scans, includes, MRI, CT scan, PET scan	$300.00 combined total copay for both technical and professional services after the deductible.	Refer to prior authorization list.

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Benefit or Service	Member Cost Share	Additional Information
Outpatient hospital (facility)	20% coinsurance after deductible no surgery performed. Or $350.00 Outpatient Hospital Facility Surgery Copay after deductible (Same as ASC)	• 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. • Includes Sleep Studies
Outpatient Professional , Physician and Surgical services (surgeon, asst. surgeon, midwife/midwives, radiologist, pathologist)	$75.00 copay after deductible Other services 20% after deductible	• 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	
Mental health visits (outpatient, professional)	$15.00 copay not subject to the deductible	
Outpatient rehabilitation services (physical (PT), speech (ST), occupational therapy (OT)	$25.00 copay not subject to the deductible	25 combined visit limit per calendar year. Limit does not apply to these services with a behavioral health (mental health) diagnosis. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 25 visits.
Outpatient substance disuse, SUD, chemical dependency visits (professional)	$15.00 copay not subject to the deductible	Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.
Spinal Manipulations (not chiropractor)	20% coinsurance after the deductible.	See separate benefit for Chiropractors.

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Benefit or Service	Member Cost Share	Additional Information
Surgery, ambulatory surgical centers (ASC)	$350.00 copay, after deductible. Copay cannot exceed the actual cost of the service. For example if the service is $150.00 the copay will be $150.00.	• 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.
Over the Counter (OTC) medication/pharmacy	See Pharmacy in this grid for more information.NOT COVERED except FDA approved, FDA-approved over-the-counter contraceptive products, such as condoms, sponges and spermicides. OTC Covid Tests are not covered.	
Partial hospitalization service intensive outpatient mental health services (facility)	$15.00 for E & M service not subject to deductible Other services 20% coinsurance subject to deductible	Refer to prior authorization list.
Outpatient substance disuse, SUD, chemical dependency (facility)	$15.00 for E & M service not subject to deductible Other services 20% coinsurance subject to deductible	Refer to prior authorization list. Includes outpatient treatment in outpatient hospital, outpatient treatment center, and partial hospitalization or an intensive outpatient program.
Physical Exam, Periodic Exam, Annual Exam, Screenings, Preventive	$0 Cost Share	

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Benefit or Service	Member Cost Share	Additional Information
Primary Care Physician (PCP) office visits	$15.00 for E & M service not subject to deductible Other services 20% coinsurance subject to deductible	• 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
Podiatry Services (Routine Foot Care)	$0	Covered if medically necessary
Podiatry Services (Foot Care) Medical Covered	$0	Covered if medically necessary

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Prescription drugs, pharmacy,Rx	Not subject to the deductible: •Asthma inhalers/ epinephrine auto injectors/EpiPen -$35.00, 30-day Supply • Insulin, $35, 30-day supply • Generic, $10, 30-day • Generic, $27, 90-day supply • Preferred, $60.00, 30-day supply • Preferred, $162, 90-day supply •Non-Preferred, $100 copay 30-day supply. Limited to 30-day supply. •Specialty Rx $100.00 copay 30-day supply. Limited to 30-day supply.	Refer to prior authorization list. • 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, such as condoms, 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: • Every 12 months: Digital rectal exam • Every 12 months PSA test
Prosthetic devices and related supplies	20% coinsurance after deductible	Refer to prior authorization list. 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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Benefit or Service	Member Cost Share	Additional Information
Pulmonary rehabilitation services	20% 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	Cost share determined by service: Inpatient hospital copays, outpatient facility, surgeon, anesthesia, etc. Other - 20% after deductible	Refer to prior authorization list. 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	
Skilled nursing inpatient facility (SNF) care	Days: 1-5 - $350.00 per day after the deductible. No more than 5 days of copayments per stay after the deductible. Professional: All inpatient professional services 20% coinsurance after the deductible.	Refer to prior authorization list. Coverage is limited to 60 inpatient days per year • 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. Not Covered: Maintenance and Custodial Care are not covered.

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Benefit or Service	Member Cost Share	Additional Information
Smoking and tobacco use cessation	0% Coinsurance with Alere Or 20% Coinsurance other providers	0% Coinsurance with through Alere Quit-for-Life smoking cessation program. 40% Coinsurance if not Alere Quit-for-Life smoking cessation program
Sterilization Reversal	Not Covered	Not Covered reversal of surgical sterilization, including any direct or indirect complications thereof.
Specialist Visit	$40.00 for E & M service Not Subject to Deductible Other services 20% coinsurance	• 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: •Inpatient Physician and Surgical 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 20% afer deductible.	
Transplant Evaluation/Work-Up	Cost share determined by service: Office Visit, Lab, etc.	Refer to prior authorization list.
Transplant	Cost share determined by service: Inpatient hospital copays, anesthesia, etc.	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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Benefit or Service	Member Cost Share	Additional Information
Transportation Non-emergency	Not covered	For emergency see Ambulance
Unlisted Codes with Charge Greater Than $250.00		Refer to prior authorization list. 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	$35.00 Copay E & M code not Subject to the deductible. Other services 20% after 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 copay.
Wig (Covered under DME)	20% 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.
Temporomandibular Joint Disorders, TMJ	Cost share determined by service, e.g. outpatient hospital copay, specialist visit, surgery, etc.	Refer to prior authorization list.

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Benefit or Service	Member Cost Share	Additional Information
Maternity, OB Care, Prenatal, Postnatal, pregnancy	Cost share determined by service: Inpatient hospital copays, anesthesia, postnatal care, etc.	Global OB physician care (prenatal, delivery and postpartum care) 0% cost share • No cost share for hospital visits. • Inpatient hospital facility copays. $525.00 per day. No more than 5 days of copayments per stay. • Birthing Center facility fee $350 Copay after deductible • Professional fee in Birthing Center 0% cost share • Postnatal Care includes lactation support and counseling is $15.00 copay for E & M service and 30% coinsurance for other services.
Well Baby, Newborn, preventive, donor milk	$0 Cost Share	Effective 1/1/2026: Donor Human Milk is covered when inpatient under Newborn Care.
Radiation	20% coinsurance after deductible	
Transgender Treatment and Surgery	Cost share determined by service, e.g. outpatient hospital copay, specialist visit, etc.	Refer to prior authorization list.
Massage Therapy	Not Covered	Not Covered
Other Practitioner, includes naturopath, nurse practitioner or physician assistant (if not PCP)	$15.00 for E & M service deductible does not apply. Other services 20% coinsurance subject to deductible	• 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
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.

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Prenatal Congenital Anomalies Office Visits	$15.00 copay for E & M service, not subject to the deductible. Other services 20% coinsurance after the deductible.	• Copay applies to E & M (visit) only • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply
Sleep Studies	20% coinsurance after deductible	Refer to prior authorization list. Sleep Studies covered under Outpatient Facility Benefit.
Surrogacy, surrogate mother, surrogate pregnancy	NOT COVERED	Surrogacy, surrogate mother, surrogate pregnancy, an assisted reproduction process, resulting in pregnancy of a child intended for other parents.