Benefit or Service	Member Cost Share	Additional Information
Abortion, Voluntary Termination of Pregnancy (Surgeon)	Cost shares determined by the service. • Inpatient Surgeon20% coinsurance after deductible • Inpatient hospital copay after deductible applies • Outpatient Surgeon 20% coinsurance after deductible • Outpatient facility fee if applies • Other 20% coinsurance after 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	$10.00 Copay	Limited to 12 visits per year calendar year. Unlimited visits for chemical dependency treatment,SUD, substance disuse.
Allergy Care	20% coinsurance after deductible	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	$175.00 copay	
Ambulance (Non-Emergency)	NOT COVERED	NOT COVERED

Benefit or Service	Member Cost Share	Additional Information
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.
Applied Behavior Analysis Therapy (ABA)	20% coinsurance after deductible	Refer to prior authorization list. 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)	$325.00 Copay after deductible	
Bariatric Surgery	NOT COVERED	NOT COVERED
Bone mass measurement (Bone Density)	$0 Cost Share	Prior authorization 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 and cost shares.
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.

Benefit or Service	Member Cost Share	Additional Information
Cervical and vaginal cancer screening (Pap tests, pelvic exams)	$0 Cost Share	For planned preventive services that become diagnostic during the screening, cost sharing may apply. • All women: Every 24 months • High risk of cervical cancer or abnormal pap: Every 12 months
Chemotherapy	20% coinsurance after deductible	
Chiropractor services	$10.00 copay *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 copay, specialist visit, etc.	Refer to prior authorization list.
Colorectal cancer screening (Colonoscopy, Sigmoidoscopy)	$0 Cost Share	For planned preventive services that become diagnostic during the screening, cost sharing may apply. For age 50 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.
Cosmetic surgery or procedures	NOT COVERED	NOT COVERED

Benefit or Service	Member Cost Share	Additional Information
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	$750.00 includes any Rx subject to deductible for in network providers.	
Deductible,Family	$1500.00 includes any Rx subject to deductible for in network providers.	
Dental Medical Services (Not Routine Dental), Oral Surgery (Surgeon)	Cost shares determined by the service. • Inpatient Surgeon20% coinsurance after deductible • Inpatient hospital copay after deductible applies • Outpatient Surgeon $120.00 copay after deductible • Outpatient facility fee if applies • 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	

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)	20% coinsurance after deductible	Refer to prior authorization list. Prior Authorization 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	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
Emergency Room Facility, Out of Area	$425.00 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 after the deductible.	Emergency Care Only. 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. Same as in-network cost shares.
Emergency Room, ER (facility)	$425.00 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 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.
Enteral Feedings, Tube Feedings,PKU	20% coinsurance after deductible	Refer to prior authorization list.

Benefit or Service	Member Cost Share	Additional Information
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)	20% coinsurance after deductible	Covered, Exams to diagnose diseases and conditions of the eye. Includes retinal exam for diabetes. Not covered, Orthoptics or vision training and any associated supplemental testing.
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.

Benefit or Service	Member Cost Share	Additional Information
Eye Wear - Medical Vision Hardware	20% 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

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	Not Covered	Not covered: Eyeglasses or contact lenses for conditions not listed under medical eye wear,vision hardware or covered under the Pediatric Vision benefit.

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. • 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.

Benefit or Service	Member Cost Share	Additional Information
Habilitative Inpatient	Days: 1-5 - $425.00 per day No more than 5 days of copayments per stay. $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.
Habilitative Outpatient	$20.00 copay	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)	20% 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
Hearing services, Cochlear Implants	Cost share determined by service: Outpatient Surgeon $75.00 copay, facility fee if applicable, 20% coinsurance after deductible for DME (implants), anesthesia, etc.	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.

Benefit or Service	Member Cost Share	Additional Information
Home health agency care	$10.00 copay not subject to after deductible	130 Days per year limit •Refer to prior authorization list. 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. Review Prior Authorization list for related services. • 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 in Home $10.00 copay not subject to after 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.

Benefit or Service	Member Cost Share	Additional Information
Hospice Respite Care	in Home $10.00 copay not subject to after deductible.	Refer to prior authorization list. 14 Days per year limit
Hyperbaric oxygen treatment	20% coinsurance after deductible	Refer to prior authorization list.
Immunizations	$0 Cost Share	Immunizations administered by pharmacists must be billed as a professional claim (HCFA form).
Infertility Diagnostic Services	Cost share determined by service: Surgeon, facility fee if applicable, 20% coinsurance after deductible for, anesthesia, etc.	Prior Authorization is required for services provided in an inpatient setting. 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. Not covered: Treatments and procedures for the purposes of producing a pregnancy are not covered.
Infusion Therapy	20% coinsurance after deductible	Prior authorization 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.

Benefit or Service	Member Cost Share	Additional Information
Injections, Injectable drugs	20% after deductible.	Refer to prior authorization list. Note: All Unclassified biologics (J3590) require a prior authorization. Covered 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	
Outpatient Blood	20% coinsurance after deductible	

Benefit or Service	Member Cost Share	Additional Information
Inpatient hospital (acute) care	Days: 1-5 - $425.00 per day No more than 5 days of copayments per stay. Professional: • $0 Cost Share performed inpatient for surgeons, asst. surgeon and pathologist professional services. All other inpatient professional services 20% coinsurance after the deductible. EXCEPTIONS: • Reconstructive surgery - inpatient - 20% coinsurance after the deductible • Transplant surgery - inpatient - 20% coinsurance after the deductible • Voluntary Termination of Pregnancy - inpatient - 20% coinsurance after the 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.
Inpatient Professional Services including SNF	Cost share determined by service	

Benefit or Service	Member Cost Share	Additional Information
Inpatient Hospital mental health, psychiatric, psychiatrist-care (facility)	Days: 1-5 - $425.00.00 per day No more than 5 days of copayments per stay. $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.
Inpatient rehabilitation (facility)	Days: 1-5 - $425.00 per day No more than 5 days of copayments per stay. $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 - $425.00 per day No more than 5 days of copayments per stay. $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	$10 copay after deductible	Does not apply to diabetics. See Diabetic Education and Diabetic Nutrition Education for additional information.

Benefit or Service	Member Cost Share	Additional Information
Nurse Advice Line	0% cost share	24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006
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 this 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.

Benefit or Service	Member Cost Share	Additional Information
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	$2400.00 includes copays including pharmacy and all services applied to deductibles for in-network services.	
Out of Pocket Max. Per Year, MOOP, Family, includes pharmacy	$4800.00 includes copays including pharmacy and all services applied to deductibles for in-network services.	
Orthotics	20% coinsurance after deductible	Refer to prior authorization list. Prior Authorization required if purchase is $500.00 or more or rental is $500.00 per month or more This benefit does not cover off-the-shelf shoe inserts or orthopedic shoes.
Outpatient Lab and Pathology	$20.00 copay 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 pathology copay when inpatient

Benefit or Service	Member Cost Share	Additional Information
X-ray, Radiology (does not include scans)	$40.00 Copay	•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, imaging,scans, includes, MRI, CT scan, PET scan	20% after deductible	Refer to prior authorization list.
Outpatient hospital (facility)	20% coinsurance after deductible	Refer to prior authorization list. • Prior Authorization is required for certain outpatient surgery/procedures. • Professional fees are separate from the facility fees
Outpatient Surgeon and Asst. Surgeon	$120.00 copay after deductible Other 20% after deductible	
Outpatient mental health visits	$10.00 copay	
Outpatient rehabilitation services (physical (PT), speech (ST), occupational therapy (OT)	$20.00 copay	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.
Outpatient substance disuse, SUD, chemical dependency visits (professional)	$10.00 copay	Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.
Spinal Manipulations (not Chiropractors)	20% coinsurance after deductible	See separate benefit for Chiropractors.

Benefit or Service	Member Cost Share	Additional Information
Surgery, ambulatory surgical centers (ASC)	$325.00 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.	Refer to prior authorization list. • Prior Authorization is required for certain outpatient surgery/procedures. • Professional fees are separate from the facility fees
Over the Counter (OTC) medication/pharmacy	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 for more information.	
Partial hospitalization service intensive outpatient mental health services	$10.00 copay	Refer to prior authorization list.
Outpatient substance disuse, SUD, chemical dependency (facility)	$10.00 copay	Refer to prior authorization list.
Physical Exam, Periodic Exam, Annual Exam, Screenings, Preventive	$0 Cost Share	

Benefit or Service	Member Cost Share	Additional Information
Primary Care Physician (PCP) office visits	$10.00 for E & M service Other services 20% coinsurance	• 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)	DIABETICS ONLY	Routine foot care is only covered for diabetics. $0 Cost Share
Podiatry Services (Foot Care) Medical Covered	20% after deductible $0 Cost share for diabetics	
Prescription drugs, pharmacy	• Generic $12 copay for 30-day supply. 90-day supply $32.40, not subject to the deductible. • Preferred $35 copay 30-day supply. 90-day supply $94.50, not subject to the deductible. • Non-Preferred $160 copay 30-day supply, not subject to the deductible. Limited to 30-day supply. • Specialty Rx $160 copay 30-day supply, not subject to the deductible. Limited to 30-day supply. • Insulin, Limit 1-month/30 day supply, cost share $35.00, not subject to the deductible	• 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.

Benefit or Service	Member Cost Share	Additional Information
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. Prior Authorization required if purchase is $500.00 or more or rental is $500.00 per month or more Prosthetic/Orthopedic Shoes that are part of a leg brace are covered and included in the cost of the leg brace.
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 fees, 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	

Benefit or Service	Member Cost Share	Additional Information
Skilled nursing inpatient facility (SNF) care	Days: 1-5 - $425.00.00 per day after the deductible. No more than 5 days of copayments per stay. 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.
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 Care/Services (does not apply to psychiatrists, mental health, lab or radiology, naturopath, nurse practitioner or physician assistant)		$30.00 for E & M service Other services 20% coinsurance

Benefit or Service	Member Cost Share	Additional Information
Telemedicine, Telehealth (Virtual care)	Cost shares same as in person visits.	
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.
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-network only	$30.00 Copay	Out-of-area urgent care is not covered. Care is covered under the Emergency Room benefit and subject to the Emergency Care copays and coinsurance.
Wig (Covered under DME)	20% coinsurance after deductible	Must be medically necessary. Prior Authorization required if purchase exceeds $500.00.
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.	

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 $325 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	$0 Cost Share	
Radiation	20% coinsurance after deductible	
Transgender Treatment and Surgery	Cost share determined by service, e.g. outpatient hospital copay, specialist visit, etc.	
Massage Therapy	Not Covered	Not Covered
Other Practitioner, includes naturopath, nurse practitioner or physician assistant (if not PCP)	$10.00 for E & M service after 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
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.