Midwest Geriatric Management
Employee Benefit Plan – Silver HDHP
Network: National PPO (BlueCard PPO) Network
Effective Date: 01/01/2026

Benefit	In-Network	Out-Of-Network
Plan Deductible	Individual: $5,000 Family: $10,000	Individual: $10,000 Family: $20,000
Any Other Deductible	No.	No.
Deductible – Accumulation	Embedded	Embedded
Deductible – INN and OON integration	In-Network and Out-of-Network Accumulate Together	
Member Coinsurance	30%	50%
Out of Pocket Maximum	Individual: $7,000 Family: $14,000	Individual: $14,000 Family: $28,000
Out of Pocket – Accumulation	Embedded	Embedded
Out of Pocket – INN and OON integration	In-Network and Out-of-Network Accumulate Together	
Annual Benefit Maximum	Unlimited	Unlimited
Benefit Period	Calendar Year	1/1/ - 12/31

Savings Plus Plan Benefit Pricing

Savings Plus Plan benefit payment pricing of 150% of the Medicare Allowable rate applies to the following In-Network services: All in-patient and out-patient facility services; All in-patient professional and ancillary services; Surgical services – in a hospital in-patient and out-patient setting; Surgical services – in an ambulatory or free-standing surgical facility setting; All emergency services; Ambulance services - air, ground, and water; High cost diagnostic services, imaging, sleep management studies, and genetic services; dialysis/hemodialysis – all settings, all services; Infusion services – all settings, all services.
If an Out-Of-Network provider is used for these services, with the exception of Emergency Medical services and Emergency Transportation, plan payment will be based on 120% of the Medicare allowable rate.

Prescription Drug Benefits
Carelon Rx 1-833-271-2374 www.carelonrx.com

Benefit	In-Network	Out-Of-Network
Generic (Tier 1)	**No cost for Preventive Rx Drugs** **Retail 1-30-day supply:** 30% coinsurance after Deductible **Mail Order up to 1- 90-day supply:** 30% coinsurance after Deductible	If you use an Out-of-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.
Preferred (Tier 2)	**Retail 1-30-day supply:** 30% coinsurance after Deductible **Mail Order up to 1- 90-day supply:** 30% coinsurance after Deductible	If you use an Out-of-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.
Non-Limited/Non-Preferred (Tier 3)	**Retail 1-30-day supply:** 30% coinsurance after Deductible **Mail Order up to 1- 90-day supply:** 30% coinsurance after Deductible	If you use an Out-of-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount,

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		minus any applicable deductible or copayment amount.
Specialty (Tier 4)	**Retail 1-30-day supply:** 30% coinsurance after Deductible **Mail Order up to 1- 90-day supply:** 30% coinsurance after Deductible	If you use an Out-of-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.

Preventive Medical Services		
Benefit	**In-Network**	**Out-Of-Network**
Primary Care Physician Office: Adult Routine Physical - 1 visit per benefit period.	No Charge	50% Coinsurance after Deductible
Pediatrician - Well Child Care: Up to age 2 - 9 visits per benefit period Age 2 – 2 visits per benefit period Age 3 and more – 1 visit per benefit period	No Charge	50% Coinsurance after Deductible
Children Eye Exam	No Charge	50% Coinsurance after Deductible
Gynecological - Adult Routine Physical - 1 visit per benefit period.	No Charge	50% Coinsurance after Deductible
Maternity (ACA Required Prenatal /Postnatal Testing/Services only)	No Charge	50% Coinsurance after Deductible
Routine Immunizations (Child & Adult)	No Charge	50% Coinsurance after Deductible
Flu Shot (Routine)	No Charge	50% Coinsurance after Deductible
X-Rays and Lab tests (Routine)	No Charge	50% Coinsurance after Deductible
Mammography (Routine) – 1 per benefit period; Age 40 and more	No Charge	50% Coinsurance after Deductible
Pap-smear (Routine) – 1 per benefit period	No Charge	50% Coinsurance after Deductible
Prostate Cancer Screening PSA (Routine) - 1 per benefit period	No Charge	50% Coinsurance after Deductible
Colon Cancer Screening (Routine) - age 45-75 Colonoscopy – 1 in 10 years Sigmoidoscopy – 1 in 3 years	No Charge	50% Coinsurance after Deductible
Tobacco / Nicotine Use (includes services, treatment, and supplies related to addiction to or dependency on nicotine)	No Charge	50% Coinsurance after Deductible
Autism Screening (Routine) - age Birth-21	No Charge	50% Coinsurance after Deductible

LEADING EDGE ADMINISTRATORS

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Non-Preventive Medical Services			
Benefit Visit limitations are combined for In-network and Out-of-network unless otherwise specified.			
Benefit	**In-Network**		**Out-Of-Network**
Primary Care Physician Visits	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Specialist Physician Visits	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Maternity Professional – Maternity care for a Dependent Child is not covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Second Opinion – Surgical	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Telemedicine via Live Health Online at www.livehealthonline.com or 1-888-548-3432 Coverage includes Primary Care, Specialist Care, and Mental Health & Substance Use.	30% Coinsurance after Deductible		Not Covered
Non-Preventive Lab and Radiology			
Benefit	**In-Network**		**Out-Of-Network**
Lab and Pathology	**Office Setting or Independent Lab:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
X-Rays / Radiology	**Office Setting or Independent Lab:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
MRI / MRA; CT / CTA / PET Scan Genetic testing and counseling beyond ACA mandated is not covered.	**Office Setting or Independent Lab:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Sleep Studies/Sleep Management Services (Sleep Studies in the home are not covered).	**Office Setting, Home, or Independent Lab:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Inpatient Services		
Benefit	**In-Network**	**Out-Of-Network**
Pre-Surgical / Pre-Admission Testing	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab; Maternity – newborn under mother for well-baby. Preauthorization is required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Inpatient Physician Services	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Inpatient Maternity Professional	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Anesthesia	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Inpatient Surgery- Surgeon / Assistant Surgeon Charges	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse. Preauthorization is required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Inpatient Detoxification Preauthorization is required	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Inpatient Physical Medical Rehab	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Skilled Nursing Facility - Limited to 30 days per benefit period.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Outpatient Services (Note: In-Network Physician Clinic visits in an OP hospital setting – Facility claim is No Charge; Deductible waived. If the Physician Clinic visit in an Outpatient hospital setting is a Physician claim, then the applicable Copayment applies)		
Benefit	**In-Network**	**Out-Of-Network**
Outpatient Surgery Facility Preauthorization is required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Outpatient Surgery - Physician / Surgeon / Assistant Surgeon	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Anesthesia	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Home Health Care: Limited to 40 visits per benefit period. Patient is not required to be homebound. Home Health Aides are not covered.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Hospice – Inpatient and Hospice Facility. Home Hospice is not covered.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Behavioral/Mental Health & Chemical / Substance or Alcohol Abuse: Medication Management and Psych testing are covered. Eating disorders are covered, and Methadone clinics are covered. Halfway Homes are not covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Partial Hospitalization and Intensive Outpatient Therapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Therapy Services			
Benefit	**In-Network**		**Out-Of-Network**
Autism Spectrum Disorder – ABA Therapy is included Developmental delays are included	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Cardiac Rehabilitation - Phases 1 & 2 are covered. Phase II generally begins within 30 days after discharge from the Hospital.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Chemotherapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Chiropractic Care	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Dialysis / Hemodialysis Home Dialysis is covered	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Gene / Cellular Therapy	Not Covered	Not Covered	Not Covered
Growth Hormone Therapy	Not Covered	Not Covered	Not Covered
Home Infusion	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Home visits – Professional (not part of Home Health visits/ Home Health Aid Services)	Not Covered		Not Covered
Infusion Therapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Medical Nutrition Therapy	**Professional Non-Facility based Services:**	**Facility based Services:**	50% Coinsurance after Deductible

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	30% Coinsurance after Deductible	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	
Occupational Therapy - Not combined with any other benefit.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Physical Therapy - Not combined with any other benefit.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Pulmonary/Respiratory Therapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Radiation Therapy	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Speech Therapy - Not combined with any other benefit.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Emergency Services			
Benefit	**In-Network & Out-Of-Network**		
Emergency Care	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		
Emergency Medical Transportation: Ground or Air Ambulance are covered.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		
Urgent Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Other Services			
Benefit	**In-Network**		**Out-Of-Network**
Abortion - Therapeutic only. Elective abortion is not covered. Maternity care for a Dependent child is not covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Acupuncture	Not Covered		Not Covered
Allergy Injections	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Allergy Testing	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Alternative Medicine	Not Covered		Not Covered

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Ambulance Service – Non Emergency Transport. Ground or air transport.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		50% Coinsurance after Deductible
Bariatric treatment (surgery is not covered). Treatment is limited to Charges for diagnostic services and Nutritional counseling only.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Biofeedback	Not Covered		Not Covered
Blood Processing / Blood Storage (blood donor expenses are not covered)	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Dental – Accident to sound teeth only. Treatment must be started within 12 months of injury. Routine Dental is excluded. Dental Anesthesia for those 5 and under, due to intellectual disabilities, or because an individual has medical conditions that may cause undue medical risk is covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. Breast Pumps are covered at 100%; Manual pumps – limited to 1 every pregnancy	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Foot Care (routine) – Diabetic / Circulatory diagnosis only.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Foot Care (routine) – Non-Diabetic	Not Covered	Not Covered	Not Covered
Gender Affirmation Treatment	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Gender Affirmation Surgery	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Hearing Services (exams, tests, services, and supplies to diagnose and treat a medical condition) ACA mandated Hearing exams are covered at 100% under PPACA. Hearing aids are not covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Immunization – (non-routine) Vaccinations for travel are excluded.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible

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Infertility Services - Basic Testing Only (does not include genetic testing)	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)	Not Covered	Not Covered	Not Covered
Injections	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Medical Nutrition Products – PKU formulas and enteral foods	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Medical Supplies – Includes enteral feeding supplies.	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Nutritional Counseling – Diabetic / Circulatory disease	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Nutritional Counseling – Nondiabetics	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Online visits - Telephone consultations are excluded	**PCP** and **Specialist:** 30% Coinsurance after Deductible		50% Coinsurance after Deductible
Oral Surgery – Includes removal of partially or completely impacted wisdom teeth. Dental anesthesia is covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Orthotics and Prosthetic Devices – Diabetic shoes are covered. Orthotic appliances and devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Private Duty Nursing	Not Covered		Not Covered
Respite Care – Limited to 16 hours per week	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Retail Health Clinics	30% Coinsurance after Deductible		50% Coinsurance after Deductible
Sterilization – Men are covered. Woman are covered 100% per ACA.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Sterilization Reversals	Not Covered	Not Covered	Not Covered

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TMJ Treatment	Not Covered	Not Covered	Not Covered
Vision Exams (Routine) and Hardware	Not Covered		Not Covered
Vision surgery – Eye refractions, Cataract and Glaucoma surgery includes initial frames, lenses or contact lenses.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	50% Coinsurance after Deductible
Wigs/Toupee – Post Chemotherapy or Radiation and Alopecia Areata - Limited to $500 per benefit period	30% Coinsurance after Deductible		30% Coinsurance after Deductible

Transplant Services
Centers of Excellence Locations Only

Benefit	**In-Network**	**Out-Of-Network**
Live Donor Health Services	30% Coinsurance after Deductible	Not Covered
Bone Marrow Donor Search	30% Coinsurance after Deductible	Not Covered
Organ Transplant – Facility	30% Coinsurance after Deductible	Not Covered
Organ Transplant – Physician & anesthesiologist	30% Coinsurance after Deductible	Not Covered
Travel and lodging for Organ Transplant – Maximum of $10,000 per transplant.	30% Coinsurance after Deductible	
Travel and lodging for Bone Marrow Donor Search	30% Coinsurance after Deductible	

Preauthorization
Leading Edge Administrators: 1-877-630-9550
The following services require Preauthorization, or benefit will be reduced by $500.

Inpatient Services:	**Outpatient Services:**	**Other Services:**
Cervical Spine Surgery	Cartilage Transplant Knee	Bone Stimulator
Computer Navigation for Orthopedic Surgery	Cervical Spine Surgery	Cardio/External Defibrillator
Elective Admissions	Cochlear Implant	Cooling Devices
Emergency Admissions	Computer Navigation for Orthopedic Surgery	CPAP/BIPAP
Hospice	Lumbar Spine Surgery	Electric Scooters
Lumbar Spine Surgery	Mandibular/Maxillary Surgery (Orthognathic)	Infusion Pumps
Rehabilitation Facility Admissions	Mastectomy for Gynecomastia	Insulin Pumps
Sacroiliac Joint Fusion	Nasal Septoplasty	Limb Prosthetics
Skilled Nursing Facility Admissions	Reduction Mammoplasty	Myoelectric prosthetics
Transplants	Rhinoplasty	Neuromuscular Stimulators
	Sacroiliac Joint Fusion	TENS Unit

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	Sclerotherapy (Lower Extremities)	Wheelchairs
Managed Care Services:	Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty	Wound Vacs
Inpatient BH/SA	Botulinum Toxin – Review for Migraine Use Only	Azacitidine (Vidaza)
Electric Convulsive Therapy (ECT)	Home Health Services	Bevacizumab (Avastin) – Review for Non-Eye Only
Intensive Outpatient Therapy	Home Hospice	Bortezomib (Velcade)
Partial Hospitalization (PHO)	Hyperbaric Oxygen Therapy (Systemic/Topical)	Etanercept (Enbrel)
Residential Care (RTC)	Coronary CT Angiography (CCTA)	Fulvestrant (Faslodex)
Psychological testing	Coronary MRA	Immune Globulin (Intravenous)
Genetic Counseling	Cardiac MRI	Infliximab (Remicade)
	MRA of the Head and/or Neck	Ipilimumab (Yervoy)
	MRI of the Brain	Nivolumab (Opdivo)
	MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral	Paclitaxel (Abraxane Only)
	PET Scan	Panitumubab (Vectibix)
	Physical/Occupational/Speech Therapy	Pembrolizumab (Keytruda)
		Pemetrexed (Alimta)
Maternity Care for dependent daughters except ACA allowed		Rituximab (Rituxan) – Review for Non-Oncology Diagnosis/Treatment Only

Exclusions
In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan

Abortion - Elective	Hearing Aids
Acupuncture	Long-Term Care
Alternative Medicine/homeopathy	Massage Therapy
Aquatic Therapy	Maternity Care for dependent daughters except ACA allowed
Arch supports (supportive shoe inserts)	Methadone Clinics
Bariatric Surgery (coverage limited to non-surgical treatment)	Non-Emergency Care outside the U.S.
Bereavement Counseling	Orthopedic Shoes/ orthopedic inserts
Biofeedback	Routine Eye Care (Adult) and Child except ACA allowed
Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy or breast reductions)	Self-Inflicted unless result of medical condition
Custodial Care	Vision Exam and Hardware
Dental Care (Routine) Adult and Child except ACA allowed	Weight Loss Programs
Gene/Cellular Therapy	
Growth Hormone Therapy	
Halfway house/home – non-healthcare residential facility	