LEADING EDGE ADMINISTRATORS

**Public Partnership, LLC**
**Employee Benefit Summary – Anthem Bronze Beyond Value Plan**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| Benefit | In-Network | | Out-Of-Network |
|---|---|---|---|
| Plan Deductible | $6,350 Individual<br>$12,700 Family | | $12,700 Individual<br>$25,400 Family |
| Any Other Deductible | N/A | | N/A |
| Deductible – Accumulation | Embedded | | Embedded |
| Deductible – INN and OON integration | In-Network and Out-of-Network accumulate separately | | |
| Member Coinsurance | 0% | | 50% |
| Out of Pocket Maximum | $6,350 Individual<br>$12,700 Family | | $12,700 Individual<br>$25,400 Family |
| Out of Pocket – Accumulation | Embedded | | Embedded |
| Out of Pocket – INN and OON integration | In-Network and Out-of-Network accumulate separately | | |
| Annual Benefit Maximum | Unlimited | | Unlimited |
| Benefit Period | Calendar Year | 1/1 – 12/31 | |

| **Prescription Drug Benefits**<br>**Carelon Rx 1-833-271-2374 www.anthem.com** | | |
|---|---|---|
| **Cost Share listed apply after Plan deductible has been met.** | | |
| Generic (Tier 1) | **No cost for Preventive Rx Drugs**<br>**30-day supply:** No Charge after Plan Deductible<br>**Mail Order up to 90-day supply:** No Charge after Plan Deductible | Not Covered |
| Preferred (Tier 2) | **30-day supply:** No Charge after Plan Deductible<br>**Mail Order up to 90-day supply:** No Charge after Plan Deductible | Not Covered |
| Non-Limited/Non-Preferred (Tier 3) | **30-day supply:** No Charge after Plan Deductible<br>**Mail Order up to 90-day supply:** No Charge after Plan Deductible | Not Covered |
| Specialty (Tier 4) | **30-day supply:** No Charge after Plan Deductible<br>**Retail 30-day supply:**<br>No Charge after Plan deductible<br>**Retail:** Prescription cost limitation of $24,000 per benefit period. Once the benefit period maximum is met the member will be responsible for the full cost of the medication.<br>**Mail Order:** Not Covered | Not Covered |

**Beyond Value Plan Benefit Pricing**

**Beyond Value 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.**

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| Preventive Medical Services | | |
|---|---|---|
| **Benefit** | **In-Network** | **Out-Of-Network** |
| Primary Care Physician Office:<br>Adult Routine Physical - 1 visit per benefit period. | No Charge (Deductible Waived) | Not Covered |
| Pediatrician - Well Child Care:<br>Up to age 2 - 9 visits per benefit period<br>Age 2 – 2 visits per benefit period<br>Age 3 and more – 1 visit per benefit period | No Charge (Deductible Waived) | Not Covered |
| Children Eye Exam | No Charge (Deductible Waived) | Not Covered |
| Gynecological - Adult Routine Physical - 1 visit per benefit period. | No Charge (Deductible Waived) | Not Covered |
| Maternity (ACA Required Prenatal /Postnatal Testing/Services only) | No Charge (Deductible Waived) | Not Covered |
| Routine Immunizations (Child & Adult) | No Charge (Deductible Waived) | Not Covered |
| Flu Shot (Routine) | No Charge (Deductible Waived) | Not Covered |
| X-Rays and Lab tests (Routine) | No Charge (Deductible Waived) | Not Covered |
| Mammography (Routine) – 1 per benefit period; Age 40 and more | No Charge (Deductible Waived) | Not Covered |
| Pap-smear (Routine) – 1 per benefit period | No Charge (Deductible Waived) | Not Covered |
| Prostate Cancer Screening PSA (Routine) - 1 per benefit period | No Charge (Deductible Waived) | Not Covered |
| Colon Cancer Screening (Routine) - age 45-75<br>Colonoscopy – 1 in 10 years<br>Sigmoidoscopy – 1 in 3 years | No Charge (Deductible Waived) | Not Covered |

| Non-Preventive Medical Services | | | |
|---|---|---|---|
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Primary Care Physician Visits | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Specialist Physician Visits | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Maternity Professional – Maternity care for a dependent child is excluded. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Second Opinion – Surgical | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Chiropractic Care – Limited to 30 visits per benefit period | **Professional Non-Facility based Services:**<br>No Charge after Deductible | | 50% Coinsurance after Deductible |

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| | | | |
|---|---|---|---|
| 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. | No Charge after Deductible | | Not Covered |
| **Non-Preventive Lab and Radiology** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Lab and Pathology | **Office Setting or Independent Lab**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| X-Rays / Radiology | **Office Setting or Independent Lab**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| MRI / MRA; CT / CTA / PET Scan; Genetic testing and counseling beyond ACA mandated is covered. Preauthorization is required. | **Office Setting or Independent Lab**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Sleep Studies/Sleep Management Services | **Office Setting, Home, or Independent Lab**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| **Inpatient Services** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Pre-Surgical / Pre-Admission Testing | No Charge after Deductible<br>*Beyond Value 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. | No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Inpatient Physician Services | No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Inpatient Maternity Professional | No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Anesthesia | No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Inpatient Surgery- Surgeon/ Assistant Surgeon Charges | No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse. Preauthorization is required. | No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Inpatient Detoxification Preauthorization is required. | No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |

| Inpatient Physical Medical Rehabilitation – Limited to 120 days per benefit period. (Combined limit with Skilled Nursing Facility) Limit is combined INN/OON. Preauthorization is required. | No Charge after Deductible *Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
|---|---|---|---|
| Skilled Nursing Facility - Limited to 120 days per benefit period. (Combined limit with Inpatient Physical Medical Rehabilitation) Limit is combined INN/OON. Preauthorization is required. | No Charge after Deductible *Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| **Outpatient Services** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Outpatient Surgery Facility Preauthorization is required. | No Charge after Deductible *Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Outpatient Surgery -Physician / Surgeon / Assistant Surgeon | No Charge after Deductible *Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Anesthesia | No Charge after Deductible *Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Home Health Care – Limited to 120 visits per benefit period. Combined limit with Home Infusion. Limit is combined INN/OON. Patient not required to be homebound. Home Health Aides are covered. Preauthorization is required. | No Charge after Deductible | | 50% Coinsurance after Deductible |
| Hospice – Facility or Home Preauthorization is required. | **Home Setting:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Behavioral/Mental Health & Chemical / Substance or Alcohol Abuse: Medication Management, Psych testing, Eating disorders, Bereavement counseling, Partial Hospitalization, Intensive Out-patient Therapy, and Methadone clinics are covered. Halfway Homes are not covered. Preauthorization is required for certain services. | **Professional Non-Facility based Services:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| **Therapy Services** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Aural Therapy | Not Covered | | Not Covered |
| Autism Spectrum Disorder – ABA Therapy is included Developmental delays included | **Professional Non-Facility based Services:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |

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| | | | |
|---|---|---|---|
| Cardiac Rehabilitation | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Chemotherapy | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Gene / Cellular Therapy | Not Covered | | Not Covered |
| Dialysis / Hemodialysis<br>Home Dialysis is covered | **All Settings including Outpatient Facility, Office, and Home:** No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Home Infusion – Limited to 120 visits per benefit period. Combined limit with Home Health Care. Limit is combined INN/OON. Patient not required to be homebound. | No Charge after Deductible<br>*Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Home visits – Professional | No Charge after Deductible | | 50% Coinsurance after Deductible |
| Infusion Therapy | **Professional Non-Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Medical Nutrition Therapy | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Occupational Therapy - Limited to 30 visits per benefit period. Combined limit with Physical and Speech Therapy. Limit is combined INN/OON. Preauthorization is required. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Orthoptic / Pleoptic Therapy<br>Limited to 8 visits per lifetime. Limit is combined INN/OON. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Physical Therapy - Limited to 30 visits per benefit period. Combined limit with Occupational and Speech Therapy. Limit is combined INN/OON. Preauthorization is required. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Pulmonary/Respiratory Therapy | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Radiation Therapy | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |

| | | | |
|---|---|---|---|
| Speech Therapy - Limited to 30 visits per benefit period. Combined limit with Occupational and Physical Therapy. Limit is combined INN/OON. Preauthorization is required. | **Professional Non-Facility based Services:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| **Emergency Services** | | | |
| **Benefit** | **In-Network & Out-Of-Network** | | |
| Emergency Care | No Charge after Deductible *Beyond Value Plan Benefit* | | |
| Emergency Medical Transportation: Ground, Air, and Water Ambulance are covered. | No Charge after Deductible *Beyond Value Plan Benefit* | | |
| Urgent Care | No Charge after Deductible<br>Out-of-Network Urgent Care Services covered as In-Network<br>Facility based Services are a Savings Plus Plan Benefit | | |
| **Other Services** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Abortion - Therapeutic Only (Elective not covered) maternity care for a dependent child is excluded. Complications from elective abortion is covered. | **Professional Non-Facility based Services:** No Charge after Deductible | **Outpatient / Inpatient Facility:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Acupuncture - Limited to 15 visits per benefit period. | **Professional Non-Facility based Services:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Allergy Services / Injections | **Professional Non-Facility based Services:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Allergy Testing | **Professional Non-Facility based Services:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Alternative Medicine | Not Covered | | Not Covered |
| Ambulance Service – Non-Emergency Transport Ground Ambulance only. | No Charge after Deductible *Beyond Value Plan Benefit* | | 50% Coinsurance after Deductible |
| Bariatric Surgery | Not Covered | | Not Covered |
| Biofeedback | Not Covered | | Not Covered |
| Blood Processing / Blood Storage; Includes autologous donation and storage up to 30 days. | **Professional Non-Facility based Services:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Dental – Accident to sound teeth only. Treatment must be started within 3 months of injury. Routine Dental is excluded. Dental Anesthesia for those 7 and under is covered. | **Professional Non-Facility based Services:** No Charge after Deductible | **Facility based Services:** No Charge after Deductible *Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. | No Charge after Deductible | | 50% Coinsurance after Deductible |

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| Breast Pumps are covered at 100% per PPACA Guidelines; Electric pumps – limited to 1 every 36 months. Manual pumps – limited to 1 every pregnancy; Preauthorization is required on certain items. | | | |
|---|---|---|---|
| Foot Care (routine) – Diabetic only. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Gender Affirmation Surgery | Not Covered | | Not Covered |
| Hearing Aids Hearing Aids - (exams, fittings, and device) Limited to 1 device per ear every 3 years. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Immunization (non-routine) Vaccinations for travel are excluded | No Charge after Deductible | | 50% Coinsurance after Deductible |
| Infertility Services - Basic Testing Only. Infertility treatment is excluded | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF) | Not Covered | | Not Covered |
| Injections | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Medical Nutrition Products – PKU formulas and enteral feeding supplies. Over the counter formula, even with a prescription, is excluded. | No Charge after Deductible | | 50% Coinsurance after Deductible |
| Medical Supplies | No Charge after Deductible | | 50% Coinsurance after Deductible |
| Nutritional Counseling – Diabetic; Limited to 6 visit per benefit period. Limit is combined INN/OON. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Nutritional Counseling – Nondiabetics Limited to 6 visit per benefit period.<br>Limit is combined INN/OON. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Online visits - Telephone consultations are excluded | No Charge after Deductible | | 50% Coinsurance after Deductible |
| Oral Surgery – Includes removal of impacted wisdom teeth. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Orthotics and Prosthetic Devices – Diabetic shoes are covered. | No Charge after Deductible | | 50% Coinsurance after Deductible |
| Private Duty Nursing | Not Covered | | Not Covered |
| Respite Care | Not Covered | | Not Covered |
| Retail Health Clinics | No Charge after Deductible | | 50% Coinsurance after Deductible |
| Sterilization – Men are covered at Deductible and coinsurance. Woman are covered 100% per PPACA guidelines. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |

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| | | | |
|---|---|---|---|
| Sterilization Reversals | Not Covered | | Not Covered |
| TMJ Treatment & Appliances | Not Covered | | Not Covered |
| Vision Exams (Routine) and Hardware | Not Covered | | Not Covered |
| Vision surgery – Post Cataract and Glaucoma surgeries coverage is provided for initial frames, lenses, or contacts. | **Professional Non-Facility based Services:**<br>No Charge after Deductible | **Facility based Services:**<br>No Charge after Deductible<br>*Beyond Value Plan Benefit* | 50% Coinsurance after Deductible |
| Wigs – After Chemotherapy or Radiation | No Charge after Deductible | | 50% Coinsurance after Deductible |

| **Transplant Services**<br>**Centers of Excellence Locations Only** | | |
|---|---|---|
| **Benefit** | **In-Network** | **Out-Of-Network** |
| Live Donor Health Services | No Charge after Deductible | Not Covered |
| Bone Marrow Donor Search – Limited to $10,000 Per Benefit period | No Charge after Deductible | Not Covered |
| Organ Transplant – Facility | No Charge after Deductible | Not Covered |
| Organ Transplant – Physician & anesthesiologist | No Charge after Deductible | Not Covered |
| Travel and lodging for Organ Transplant | Maximum of $25,000 per Transplant | |
| Travel and lodging for Bone Marrow Donor Search | Maximum of $5,000 per Benefit period | |

| **Preauthorization: AlefHealth 1-813-547-3110**<br>The following services require Preauthorization, or benefit will be reduced by 50%. | | |
|---|---|---|
| **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 |
| | Sclerotherapy (Lower Extremities) | Wheelchairs |
| **Managed Care Services:** | Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty | Wound Vacs |

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| | | |
|---|---|---|
| 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) |
| | | 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 | Long-Term Care |
| Alternative Medicine/homeopathy | Massage Therapy |
| Aquatic Therapy | Maternity Care for a Dependent Child |
| Arch supports (supportive shoe inserts) | Non-Emergency Care outside the U.S. |
| Bariatric Surgery | Orthopedic Shoes/ orthopedic inserts – Non-diabetic |
| Biofeedback | Private-duty Nursing |
| Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy) | Respite Care |
| Custodial Care | Routine Eye Care (Adult) and Child except ACA allowed |
| Dental Care (Routine) Adult and Child except ACA allowed | Routine Foot Care (non-diabetic/metabolic disease) |
| Gender Affirmation Surgery | Self-Inflicted unless result of medical condition |
| Gene & Cellular Therapy | Sterilization Reversals |
| Growth Hormone Therapy | TMJ Treatment and Appliances |
| Halfway house/home – non-healthcare residential facility | Vision Exam and Hardware |
| Infertility Services (Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF) | Weight Loss Programs |