| Geisinger All-Access PPO 20/40/1500 | | Gold |
|---|---|-----------------------|
| Summary of Benefits | In-Network | Out-of-Network |
| Maximum Out of Pocket for Medical EHB Benefits | NA | NA |
| Maximum Out of Pocket for Drug EHB Benefits | NA | NA |
| Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) | \$9,100/\$18,200 | \$15,000/\$30,000 |
| Medical EHB Deductible (Embedded) | \$1,500/\$3,000 | \$5,000/\$10,000 |
| Drug EHB Deductible | \$0/\$0 | Limited to In Network |
| Combined Medical and Drug EHB Deductible | NA | NA |
| Coinsurance | 0% | 30% |
| Primary Care Visit to Treat an Injury or Illness | \$20 | 30% after deductible |
| Specialist - Office Visit | \$40 | 30% after deductible |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | \$20 | 30% after deductible |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | \$150 copay after deductible | 30% after deductible |
| Outpatient Surgery Physician/Surgical Services | 0% after deductible | 30% after deductible |
| Hospice Services | Residential - \$40 per visit, Facility - \$100 per day | 30% after deductible |
| Infertility Treatment (Note Exclusions) | 0% after deductible | 30% after deductible |
| Routine Eye Exam (Adult) | Not Covered | Not Covered |
| Urgent Care Centers or Facilities | \$20 | \$20 |
| Home Health Care Services (60 visits per year - visit limits do not apply to mental health/ substance use disorder benefits) | \$0 | 30% after deductible |
| Emergency Room Services | \$200 | \$200 |
| Emergency Transportation (Ambulance/Air) | \$0 | \$0 |
| Inpatient Hospital Services (e.g., Hospital Stay) | \$200 per stay after deductible | 30% after deductible |
| Inpatient Physician and Surgical Services | 0% after deductible | 30% after deductible |
| Skilled Nursing Facility (120 days per year) | 0% after deductible | 30% after deductible |
| Prenatal and Postnatal Care (Office Visit) | \$0 | 30% after deductible |
| Delivery and All Inpatient Services for Maternity Care | 0% after deductible | 30% after deductible |
| Mental/Behavioral Health Outpatient Services | \$20 | 30% after deductible |
| Mental/Behavioral Health Inpatient Services | \$200 per stay after deductible | 30% after deductible |
| Substance Abuse Disorder Outpatient Services | \$20 | 30% after deductible |
| Substance Abuse Disorder Inpatient Services | \$200 per stay after deductible | 30% after deductible |
| Tier 2 - Preferred Generic Drugs | \$10 | Limited to In Network |
| Tier 3 - Non-Preferred Generic Drugs | \$20 | Limited to In Network |
| Tier 4 - Preferred Brand Drugs | \$40 | Limited to In Network |
| Tier 5 - Non-Preferred Brand Drugs | \$80 | Limited to In Network |
| Tier 6 - Specialty Drugs | 40% coinsurance up to \$250 | Limited to In Network |
| Tier 1 - \$0 Rx | \$0 | Limited to In Network |
| Mail-Order Rx | 1х сорау | Limited to In Network |
| 90-Day Retail | 2x copay | Limited to In Network |
| 70 Day Notain | / | |

| Outpatient Municipations With Mark Propriets Profession Services SO SOX Aster deductible Habilitation Services \$40 SOX Aster deductible Habilitation Services \$20 United to In Network Chrispeach Cear (20 wills per benefit period) \$20 United to In Network Chrispeach Cear (20 wills per benefit period) \$150 coppy after deductible Preventive Care Streeting Planunization \$100 coppy after deductible Routine See Samt Of Utilide 10 miled to In Network Routine See Samt Of Utilide \$00 Robbilitative Seech Therapy \$40 S0X After deductible Robbilitation Occupational and Rehabilitative Physical Therapy \$40 S0X After deductible Well Bay Valis and Care - Child \$6 | Outpatient Cardiac Rehabilitation Services (36 visits per benefit period) | \$0 | 30% after deductible |
|--|---|------------------------------|-----------------------|
| Habilitation Services | | | |
| Misbilitation Speach Therapy | | | |
| Desiration of Compational and Physical Therapy | | | |
| Chiropractic Care (20 visits per benefit period) Durable Medical Equipment (cost sharing does not apply to mental health/substance use disorded (agreed) Imaging (CT/PET Scans, MRIs) Preventive Caro/Screening/Immunization Routine Eye Exam for Children Routine Eye Exam for Children Routine Eye Exam for Children Solv | | | |
| Durable Medical Equipment (cost sharing does not apply to mental health/substance use disorded diagnosis) Inanging (CYPET Scans, MRIs) Precentive Care/Screening/Immunization Rough (ECYPET Scans, MRIs) Precentive Care/Screening/Immunization Rough (ECYPET Scans, MRIs) Precentive Care/Screening/Immunization Solution Eye Exam for Children Solut | | · · | |
| diagnosis) Waster deductible United to In Network Inaging (CTYPET Scans, MRIs) \$150 copay after deductible Revenible Carce, recensing/liminalization \$0 Limited to In Network Revenible Carce, recensing/liminalization \$40 Limited to In Network Eyeglasses for Children \$0% \$0% Rehabilitative Speech Therapy \$40 30% after deductible Rehabilitative Occupational and Rehabilitative Physical Therapy \$40 30% after deductible Well Bady Visits and Care \$30 Limited to In Network Well Bady Visits and Care \$0 Limited to In Network Laboratory Outpatient \$0% after deductible 30% after deductible X rays \$0 Limited to In Network Basic Dental Care - Child \$00 coinsurance after deductible Limited to In Network Basic Dental Care - Child \$00 coinsurance after deductible 30% after deductible Align Dental Care - Child \$00 coinsurance after deductible 30% after deductible Align Dental Care - Child \$00 coinsurance after deductible 30% after deductible Align Dental Care - Child \$00 coins | | \$20 | Limited to in Network |
| Preventive Care/Screening/Immunization Routine Eye Exam for Children Syglasses for Children Syglass | | 0% after deductible | Limited to In Network |
| Routine Eye Exam for Children Eyeglasses for Children So% Rehabilitative Speech Therapy \$40 30% after deductible 30% after deductible Accidental Care Children So Cupational and Rehabilitative Physical Therapy \$40 30% after deductible So Cupationance after deductible Child (Medically necessary) Social Sourance after deductible So Cupationance after deductible Child (Medically necessary) Social Sourance after deductible So Cupationance after deductible Child (Medically necessary) Social Sourance after deductible So Cupationance after deductible Child (Medically necessary) So Cupationance after deductible So Cupationance after deductible Child (Medically necessary) So Cupationance after deductible Child (Medically necessary) So Cupationance after deductible So So Consumance after deductible So Cupationance after deductible So So Consumance after deductible So So Enter deductible So So | Imaging (CT/PET Scans, MRIs) | \$150 copay after deductible | 30% after deductible |
| Eyeglasses for Children 50% 50% Rehabilitative Speech Therapy \$40 30% after deductible Rehabilitative Occupational and Rehabilitative Physical Therapy \$40 30% after deductible Well Baby Visits and Care \$0 Limited to In Network Laboratory Outpatient 0% after deductible 30% after deductible X-rays 0% after deductible 30% after deductible Basic Dental Care - Child 50% coinsurance after Limited to In Network Basic Dental Care - Child (Medically necessary) 50% coinsurance after Limited to In Network Orthodontia - Child (Medically necessary) 50% coinsurance after Limited to In Network Accidental Care - Child 50% coinsurance after Limited to In Network Accidental Dental (medically necessary) 0% after deductible 30% after deductible Accidental Dental (medically necessary) 0% after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Chemotherapy 0% after deductible 30% after deductible Chemotherapy 0% after deductible 30% after deductible | Preventive Care/Screening/Immunization | \$0 | Limited to In Network |
| Rehabilitative Speech Therapy \$40 30% after deductible Rehabilitative Occupational and Rehabilitative Physical Therapy \$40 30% after deductible Well Baby Visits and Care \$0 Limited to In Network Laboratory Outpatient 30% after deductible 30% after deductible X-rays 0% after deductible 30% after deductible Dental Checkup for Children \$0 Limited to In Network Basic Dental Care - Child Consurance after deductible Limited to In Network Orthodontia - Child (Medically necessary) 50% coinsurance after deductible Limited to In Network Major Dental Care - Child 50% coinsurance after deductible Limited to In Network Acidental Dental (medically necessary) 0%00 coppay after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Chemotherapy 0% after deductible 30% after deductible Radiation 9% after deductible 30% after deductible Diabetes Education \$0 after deductible Initiate to | Routine Eye Exam for Children | \$40 | Limited to In Network |
| Rehabilitative Occupational and Rehabilitative Physical Therapy Well Baby Visits and Care Laboratory Outpatient Owa after deductible Scrays Owa after deductible Owa after deductible Solva Limited to In Network Laboratory Outpatient Owa after deductible Solva Limited to In Network Limited to In Network Dental Checkup for Children Solva Coinsurance after deductible Christophilid (Medically necessary) Orthodonitia - Child (Medically necessary) Orthodonitia - Child (Medically necessary) Solva Coinsurance after deductible Solva Coinsurance after deductible Safter deductible Owa after deductible Solva Safter deductible Owa after deductible Solva Safter deductible Owa after deductible Owa after deductible Solva Safter deductible Owa after deductible Owa after deductible Owa after deductible Owa after deductible Solva Safter deductible Owa after deductible Solva Safter deductible Network Inited to In Network Inited to In Network Owa after deductible Solva Safter Safter Solva | Eyeglasses for Children | 50% | 50% |
| Well Baby Visits and Care 50 Limited to In Network Laboratory Outpatient 0% after deductible 30% after deductible X-rays 0% after deductible 30% after deductible Dental Checkup for Children \$0 Limited to In Network Basic Dental Care - Child Soft coinsurance after deductible Limited to In Network Orthodontia - Child (Medically necessary) 50% coinsurance after deductible Limited to In Network Major Dental Care - Child \$000 copay after deductible 30% after deductible Accidental Dental (medically necessary) \$200 copay after deductible 30% after deductible Accidental Dental (medically necessary) 0% after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Chemotherapy 0% after deductible 30% after deductible Radiation 0% after deductible 30% after deductible Diabetes Education 0% after deductible 30% after deductible Nutritional Counseling \$40 30% after deductible Reconst | Rehabilitative Speech Therapy | \$40 | 30% after deductible |
| Laboratory Outpatient 0% after deductible 30% after deductible X-rays 0% after deductible 30% after deductible 50% coinsurance after | Rehabilitative Occupational and Rehabilitative Physical Therapy | \$40 | 30% after deductible |
| X-rays 0% after deductible 30% after deductible Dental Checkup for Children \$0 Limited to In Network Basic Dental Care - Child 50% coinsurance after deductible Limited to In Network Orthodontia - Child (Medically necessary) 50% coinsurance after deductible Limited to In Network Major Dental Care - Child 50% coinsurance after deductible Joint a Care deductible Accidental Care - Child \$200 coppay after deductible 30% after deductible Accidental Dental (medically necessary) 0% after deductible 30% after deductible Dialysis 0% after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Chemotherapy 0% after deductible 30% after deductible Radiation 0% after deductible 30% after deductible Diabetes Education 50 Limited to In Network Prosthetic Devices 0% after deductible Limited to In Network Infusion Therapy 30 30% after deductible Nutritional Counseling 340 30% after deductible Reconstructive Surgery \$200 copay after deductible 30% after deductible | Well Baby Visits and Care | \$0 | Limited to In Network |
| Dental Checkup for Children \$0 Limited to In Network Basic Dental Care - Child 50% coinsurance after deductible Limited to In Network Orthodontia - Child (Medically necessary) 50% coinsurance after deductible Limited to In Network Major Dental Care - Child 50% coinsurance after deductible Limited to In Network Transplant \$200 copay after deductible 30% after deductible Accidental Dental (medically necessary) 0% after deductible 30% after deductible Dialysis 0% after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Chemotherapy 0% after deductible 30% after deductible Radiation 0% after deductible 30% after deductible Diabetes Education \$0 Limited to In Network Prosthetic Devices 0% after deductible Limited to In Network Infusion Therapy \$0 30% after deductible Nutritional Counseling \$40 30% after deductible Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (Liper benefit period) \$0 Limited to In Network | Laboratory Outpatient | 0% after deductible | 30% after deductible |
| Basic Dental Care - Child Corthodontia - Child (Medically necessary) Major Dental Care - Child Major Dental Care - Child Sow coinsurance after deductible Sow after deductible Ilmited to In Network Infusion Therapy Sow after deductible Sow after deductible Sow after deductible Nutritional Counseling Seconstructive Surgery Sow copay after deductible Sow after deductible Sow after deductible Treventive - Physical (1 per benefit period) Sow after deductible Preventive - Physical (1 per benefit period) Sow after deductible Freventive - Pap Smears Sow Limited to In Network Preventive - Pap Smears Sow Limited to In Network Preventive - Pap Smears Sow Limited to In Network Preventive - Diabetes Freventive - Diabetes Sow Limited to In Network Preventive - Diabetes Sow Limited to In Network Imited to In Network Preventive - Diabetes Sow Limited to In Network Imited to In Network Preventive - Diabetes Sow Limited to In Network Imited to In Network Imite | X-rays | 0% after deductible | 30% after deductible |
| Basic Dental Care - Child Orthodontia - Child (Medically necessary) Major Dental Care - Child Major Dental Care - Child Major Dental Care - Child Solv coinsurance after deductible Solv after deductible Diabetes Education Solv after deductible Diabetes Education Solv after deductible Limited to In Network Infusion Therapy Solv after deductible Limited to In Network Infusion Therapy Solv after deductible Solv after deductible Limited to In Network Preventive - Physical (1 per benefit period) Preventive - Physical (1 per benefit period) Preventive - Mammograms Solv Limited to In Network Preventive - Cholesterol Solv Limited to In Network Preventive - Cholesterol Solv Limited to In Network Preventive - Cholesterol Solv Limited to In Network Preventive - Lipid Panel | Dental Checkup for Children | \$0 | Limited to In Network |
| Major Dental Care - Child Sols coinsurance after deductible Transplant Accidental Dental (medically necessary) Dialysis Allergy Testing Chemotherapy Chemotherapy Owafter deductible 30% after deductible 400 afte | Basic Dental Care - Child | | Limited to In Network |
| Transplant Sare - Child deductible summer of the Work of Accidental Dental (medically necessary) | Orthodontia - Child (Medically necessary) | | Limited to In Network |
| Accidental Dental (medically necessary) Dialysis O% after deductible Umited to In Network Prosthetic Devices O% after deductible Umited to In Network Prosthetic Devices O% after deductible Umited to In Network Infusion Therapy \$0 30% after deductible Umited to In Network \$40 30% after deductible Preventive - Physical (1 per benefit period) \$0 Limited to In Network Preventive - Physical (1 per benefit period) Preventive - Physical (1 per benefit period) Preventive - Pap Smears \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes Preventive - Lipid Panel O% after deductible Diabetes O% after deductible O% after deductible Umited to In Network O% after deductible O% afte | Major Dental Care - Child | | Limited to In Network |
| Dialysis Allergy Testing O% after deductible Diabetes Education O% after deductible Diabetes Education O% after deductible Limited to In Network O% after deductible Limited to In Network O% after deductible | Transplant | \$200 copay after deductible | 30% after deductible |
| Allergy Testing 0% after deductible 30% after deductible Chemotherapy 0% after deductible 30% after deductible Radiation 0% after deductible 30% after deductible Diabetes Education \$0 Limited to In Network Prosthetic Devices 0% after deductible Limited to In Network Infusion Therapy \$0 30% after deductible Nutritional Counseling \$40 30% after deductible Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (1 per benefit period) \$0 Limited to In Network Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Limited to In Network Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Limited to In Network | Accidental Dental (medically necessary) | 0% after deductible | 30% after deductible |
| Chemotherapy0% after deductible30% after deductibleRadiation0% after deductible30% after deductibleDiabetes Education\$0Limited to In NetworkProsthetic Devices0% after deductibleLimited to In NetworkInfusion Therapy\$030% after deductibleNutritional Counseling\$4030% after deductibleReconstructive Surgery\$200 copay after deductible30% after deductiblePreventive - Physical (1 per benefit period)\$0Limited to In NetworkPreventive - Mammograms\$0Limited to In NetworkPreventive - Pap Smears\$0Limited to In NetworkPreventive - Cholesterol\$0Limited to In NetworkPreventive - Diabetes\$0Limited to In NetworkPreventive - Diabetes\$0Limited to In NetworkPreventive - Lipid Panel\$0Limited to In Network | Dialysis | 0% after deductible | 30% after deductible |
| Radiation 0% after deductible 30% after deductible Diabetes Education \$0 Limited to In Network Prosthetic Devices 0% after deductible Limited to In Network Infusion Therapy \$0 30% after deductible Nutritional Counseling \$40 30% after deductible Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (1 per benefit period) \$0 Limited to In Network Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Allergy Testing | 0% after deductible | 30% after deductible |
| Diabetes Education \$0 Limited to In Network Prosthetic Devices 0% after deductible Limited to In Network Infusion Therapy \$0 30% after deductible Nutritional Counseling \$40 30% after deductible Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (1 per benefit period) \$0 Limited to In Network Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Chemotherapy | 0% after deductible | 30% after deductible |
| Prosthetic Devices 0% after deductible 1 Limited to In Network 1 Infusion Therapy \$0 30% after deductible 1 Nutritional Counseling \$40 30% after deductible 2 Acconstructive Surgery \$200 copay after deductible 30% after | Radiation | 0% after deductible | 30% after deductible |
| Infusion Therapy \$0 30% after deductible Nutritional Counseling Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (1 per benefit period) Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Preventive - Lipid Panel | Diabetes Education | \$0 | Limited to In Network |
| Nutritional Counseling \$40 30% after deductible Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (1 per benefit period) \$0 Limited to In Network Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Prosthetic Devices | 0% after deductible | Limited to In Network |
| Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (1 per benefit period) \$0 Limited to In Network Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Infusion Therapy | \$0 | 30% after deductible |
| Preventive - Physical (1 per benefit period) Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Nutritional Counseling | \$40 | 30% after deductible |
| Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Reconstructive Surgery | \$200 copay after deductible | 30% after deductible |
| Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Preventive - Physical (1 per benefit period) | \$0 | Limited to In Network |
| Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Preventive - Mammograms | \$0 | Limited to In Network |
| Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network | Preventive - Pap Smears | \$0 | Limited to In Network |
| Preventive - Lipid Panel \$0 Limited to In Network | Preventive - Cholesterol | \$0 | Limited to In Network |
| | Preventive - Diabetes | \$0 | Limited to In Network |
| Specialist - Procedure 0% after deductible 30% after deductible | Preventive - Lipid Panel | \$0 | Limited to In Network |
| | Specialist - Procedure | 0% after deductible | 30% after deductible |

| Colorectal - Fecal Occult and Flexible Sigmoidoscopy | \$0 | Limited to In Network |
|---|---------------------------------|-----------------------|
| Colorectal - Colonoscopy | \$0 | Limited to In Network |
| Maternity - Office diagnostic services procedures | 0% after deductible | 30% after deductible |
| Correction for Obesity - Facility | Not Covered | Not Covered |
| Ostomy Supplies | 0% after deductible | Limited to In Network |
| Urology Supplies | 0% after deductible | Limited to In Network |
| Diabetic Services/Supplies - Eye Exam | \$0 | Limited to In Network |
| Diabetic Services/Supplies - Rx Supplies | Rx copay applies | Limited to In Network |
| Diabetic Services/Supplies - Foot Orthotics | 0% after deductible | Limited to In Network |
| Diabetic Services/Supplies - Home Blood Glucose Monitor | Rx copay applies | Limited to In Network |
| Diabetic Services/Supplies - Medical Equipment | 0% after deductible | Limited to In Network |
| Implanted Devices (Medical) - Drug Delivery | 0% after deductible | 30% after deductible |
| Implanted Devices (Medical) - All other non-contraceptive implanted devices | 0% after deductible | 30% after deductible |
| Orthotic Devices | 0% after deductible | Limited to In Network |
| Outpatient Opioid Detoxification | 0% after deductible | 30% after deductible |
| Abortion (Elective) | Not Covered | Not Covered |
| High Cost Specialty Drugs/Select Injectables | \$150 | 30% after deductible |
| Injectable Drugs - Physician | \$0 | 30% after deductible |
| Injectable Drugs - Facility | 0% after deductible | 30% after deductible |
| Spinal Injections | 0% after deductible | Limited to In Network |
| Dental Anesthesia | 0% after deductible | 30% after deductible |
| Impacted Wisdom Teeth | 0% after deductible | 30% after deductible |
| Medical Foods/PKU | \$0 | Limited to In Network |
| Pulmonary Function Tests | 0% after deductible | 30% after deductible |
| Spirometry | \$0 | 30% after deductible |
| Scheduled Transportation (Ambulance/Air) | \$0 | Limited to In Network |
| Contact Lenses | 50% | 50% |
| Well Child Office Visits (0-21) | \$0 | Limited to In Network |
| Well Woman Exam | \$0 | Limited to In Network |
| Telehealth (PCP Services) | \$5 | 30% after deductible |
| Telehealth (Behavioral Health Services) | \$5 | 30% after deductible |
| Telehealth (Specialist Services) | \$10 | 30% after deductible |
| Gender-Affirming Care | \$200 per stay after deductible | 30% after deductible |
| Mental Health/Substance Abuse Urgent Care Services | \$0 | \$0 |