

Wall Street Holding Group Inc. DBA Arch Telecom Inc
Employee Benefit Summary – Gold
Network: National PPO (BlueCard PPO) Network
Effective Date: 01/1/2026

Benefit	In-Network		Out-Of-Network
Plan Deductible	\$500 Individual \$1,000 Family		\$500 Individual \$1,000 Family
Any Other Deductible	N/A		N/A
Deductible – Accumulation	Embedded		Embedded
Deductible – INN and OON integration	INN amounts apply to OON but OON does not apply to INN		
Member Coinsurance	20%		40%
Out of Pocket Maximum	\$2,000 Individual \$4,000 Family		\$2,000 Individual \$4,000 Family
Out of Pocket – Accumulation	Embedded		Embedded
Out of Pocket – INN and OON integration	INN amounts apply to OON but OON does not apply to INN		
Annual Benefit Maximum	Unlimited		Unlimited
Benefit Period	Calendar Year	1/1/-12/31	
<p>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.</p> <p>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.</p>			
Preventive Medical Services			
Benefit	In-Network		Out-Of-Network
Primary Care Physician Office: Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)		40% Coinsurance after Deductible
Pediatrician - Well Child Care: Up to age 2 - 9 visits per plan year Age 2 – 2 visits per plan year Age 3 and more – 1 visit per plan year	No Charge (Deductible Waived)		40% Coinsurance after Deductible
Children Eye Exam	No Charge (Deductible Waived)		40% Coinsurance after Deductible
Gynecological - Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)		40% Coinsurance after Deductible
Maternity (ACA Required Prenatal /Postnatal Testing/Services only)	No Charge (Deductible Waived)		40% Coinsurance after Deductible
Routine Immunizations (Child & Adult)	No Charge (Deductible Waived)		40% Coinsurance after Deductible
Flu Shot (Routine)	No Charge (Deductible Waived)		40% Coinsurance after Deductible
X-Rays and Lab tests (Routine)	No Charge (Deductible Waived)		40% Coinsurance after Deductible
Mammography (Routine) – 1 per plan year; Age 40 and more	No Charge (Deductible Waived)		40% Coinsurance after Deductible

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Pap-smear (Routine) – 1 per plan year	No Charge (Deductible Waived)	40% Coinsurance after Deductible
Prostate Cancer Screening PSA (Routine) - 1 per plan year	No Charge (Deductible Waived)	40% Coinsurance after Deductible
Colon Cancer Screening (Routine) - age 45-75 Colonoscopy – 1 in 10 years Sigmoidoscopy – 1 in 3 years	No Charge (Deductible Waived)	40% Coinsurance after Deductible

Non-Preventive Medical Services

Benefit	In-Network		Out-Of-Network
Primary Care Physician Visits	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Specialist Physician Visits	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Maternity Professional - Maternity care for Dependent Daughters is not covered	Professional Non-Facility based Services: \$20 copay per visit. 1 st Prenatal Office visit applies copayment then all other Prenatal visits are at no charge.	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Chiropractic Care – Limited to 25 visits per calendar year. Visit limit is combined in and Out-of-Network.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after deductible	40% Coinsurance after Deductible

Non-Preventive Lab and Radiology

Benefit	In-Network		Out-Of-Network
Lab and Pathology - Genetic testing beyond ACA mandated is not covered.	Office Setting: No charge	Facility based Services or Independent Lab: \$50 copay per visit <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
X-Rays / Radiology	Office Setting: No charge	Facility based Services or Independent Lab: \$50 copay per visit <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
MRI / MRA; CT / CAT / PET Scan/SPECT; Genetic testing beyond PPACA mandate is not covered. 3D mammograms are not covered.	All Settings: 20% Coinsurance after deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Sleep Studies/Sleep Management Services - Sleep Studies are covered in the patients' home. Limit 1 study per calendar year. Precertification Required.	All Settings: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible

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Inpatient Services			
Benefit	In-Network		Out-Of-Network
Pre-Surgical / Pre-Admission Testing	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab Preauthorization is required Maternity – newborn under mother for well-baby	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Inpatient Physician Services	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Inpatient Maternity Professional	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Anesthesia	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Inpatient Surgery- Surgeon/ Assistant Surgeon Charges	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse - Methadone Clinics are not covered. Eating disorders are covered. Preauthorization is required.	20% Coinsurance after deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Inpatient Detoxification (Inpatient Accommodations and Ancillaries) - Methadone Clinics and halfway houses are not covered. Preauthorization is required.	20% Coinsurance after deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Inpatient Physical Medical Rehab; Precertification is required.	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Skilled Nursing Facility - Limited to 60 days per plan year. Combined In and Out-of-Network. Does not require Inpatient Hospital stay. Precertification is required.	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Outpatient Services			
Benefit	In-Network		Out-Of-Network
Second Opinion – Surgical	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Outpatient Surgery Facility	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible

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Preauthorization is required for certain services.		
Outpatient Surgery -Physician / Surgeon / Assistant Surgeon	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Anesthesia	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Home Health Care Limited to 60 visits per calendar year. Visit maximum is combined In and Out-of-Network. Patient is not required to be homebound. Home Health Aides are covered. Precertification Required.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice – Facility or Home Setting Limit 180 days per Lifetime. Visit maximum is combined In and Out-of-Network. Precertification required.	Home Setting: 20% Coinsurance after Deductible	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>
Behavioral/Mental Health & Chemical / Substance or Alcohol Abuse - Medication Management and Psych testing are covered. Methadone clinics and Halfway homes are not covered. Intensive Outpatient Therapy and Partial Hospitalization require Preauthorization.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>
Therapy Services		
Benefit	In-Network	
		Out-Of-Network
Autism Spectrum Disorder – ABA Therapy is included Developmental delays are not covered.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>
Cardiac Rehabilitation - Precertification required for certain services.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>
Chemotherapy Precertification required for certain services.	Professional Non-Facility based Services: 20% Coinsurance after Deductible	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>
Dialysis / Hemodialysis - Home Dialysis is covered. Precertification required for certain services.	All Settings: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Gene/Cellular Therapy	Not Covered	Not Covered

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Home Infusion Therapy - Services do not count toward the Home Health visit maximum. Precertification required.	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Home visits – Professional Limited to 60 visits per calendar year.	20% Coinsurance after Deductible		40% Coinsurance after Deductible
Infusion Therapy (Provider cannot buy and bill) Precertification required for certain services.	Professional Non-Facility based Services: \$20 copay per visit <i>Savings Plus Plan Benefit</i>	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Occupational Therapy - Limited to 60 visits per calendar year. Physical Therapy Occupational Therapy and Speech Therapy Combined. Visit limit Combined In and Out-of-Network. Developmental Delays are not covered. Precertification Required.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Physical Therapy Limited to 60 visits per calendar year. Physical Therapy Occupational Therapy and Speech Therapy Combined. Visit limit Combined In and Out-of-Network. Aquatic Therapy is not covered. Massage Therapy is not covered. Developmental Delays are not covered. Precertification Required.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Pulmonary/Respiratory Therapy- Limit of 30 visits per calendar year. Precertification required for certain services.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Radiation Therapy - Precertification required for certain services.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Speech Therapy – Limited to 60 visits per calendar year. Visit limitation combined In-Network and Out-of-Network. Physical Therapy, Occupational Therapy and Speech Therapy Combined. Developmental Delays are not covered. Precertification Required.	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible

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Emergency Services			
Benefit	In-Network & Out-Of-Network		
Emergency Care – Professional and Institutional ER copay waived if admitted.	\$200 copay per visit (deductible waived) <i>Savings Plus Plan Benefit</i>		
Emergency Medical Transportation: Ground and Air, Ambulance are covered. Air Ambulance will suspend for medical necessity. Preauthorization is required within 2 business days of use.	20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		
Urgent Care	All Settings: No Charge	40% Coinsurance after Deductible	
Other Services			
Benefit	In-Network		Out-Of-Network
Abortion - Therapeutic Only Elective abortions are not covered. Maternity Care for Dependent Daughters is not covered. Precertification Required for certain services.	Office Setting: Non-specialist: \$20 copay per visit Specialist: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Acupuncture Surgical Anesthetic usage only. Routine visits are excluded.	20% Coinsurance after deductible is met		40% Coinsurance after Deductible
Allergy Services / Injections	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Allergy Testing	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Alternative Medicine	Not Covered		Not Covered
Ambulance Service – Non Emergency Transport	Not Covered		Not Covered
Bariatric Surgery	Not Covered		Not Covered
Bereavement counseling	Professional Non-Facility based Services: \$20 copay per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Biofeedback	Not Covered		Not Covered

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Blood Processing / Blood Storage Includes autologous donation	All Settings: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Dental – Covered for treatment of an injury to sound and natural teeth. Treatment must be completed within 12 months of the accident. Routine Dental is excluded. Facility and Anesthesia charges for routine dental for children are not covered.	Professional Non-Facility based Services: 20% Coinsurance after Deductible	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Durable Medical Equipment - Diabetic Supplies) – purchase and rentals. Diabetic Supplies covered by pharmacy plan are not covered under medical - including lancets syringes insulin etc. Diabetic supplies not covered under Pharmacy are covered by the medical plan. Breast pumps electrical and manual are covered at 100%. (Limited to standard (non-Hospital grade) electric or manual breast pump if requested within 60 days (electric) or 12 (manual) from baby date of birth. Limited to 1 electric/ or manual every 3 calendar years.) Precertification required for certain items. Items over \$1,000 require Precertification.	20% Coinsurance after Deductible		40% Coinsurance after Deductible
Foot Care (routine)	Not Covered		Not Covered
Gender Affirmation treatment; surgical and non-surgical	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Hearing (Non-routine Exam) ACA mandated Hearing exams are covered. Hearing Aid Services (including exams and hearing aid accessories, Hardware – Hearing Aids are not covered.	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Immunization - Vaccinations for travel are excluded	No Charge		40% Coinsurance after Deductible

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Infertility Services - Basic Infertility Services Only - Covered for services to diagnose infertility only. Treatment for underlying medical conditions are covered as medical. Treatment of infertility is not covered.	Professional Non-Facility based Services: \$20 copay/per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)	Not Covered		Not Covered
Injections (Provider cannot buy and bill) Precertification required for certain services.	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Medical Nutrition Therapy	Not Covered		Not Covered
Medical Nutrition Products – PKU formulas and enteral feeding supplies	Not Covered		Not Covered
Medical Supplies - Items over \$1,000 require Precertification	20% Coinsurance after Deductible		40% Coinsurance after Deductible
Nutritional Counseling – Diabetic Limited to 6 visit per plan year.	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Nutritional Counseling – Nondiabetics Limited to 6 visit per plan year.	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Online visits - Telephone consultations are excluded	Non-specialist copay: \$20 per visit Specialist copay: \$20 per visit		40% Coinsurance after Deductible
Oral Surgery – Includes removal of impacted wisdom teeth. Dental Anesthesia is covered only if related to a payable oral surgery. Precertification required for certain services.	Professional Non-Facility based Services: 20% Coinsurance after Deductible	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Orthotics and Prosthetic Devices – Diabetic shoes are not covered. Orthopedic shoes are only covered if integral part of a leg brace.	20% Coinsurance after Deductible		40% Coinsurance after Deductible

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Private Duty Nursing – Limited to 70 visits per calendar year. 1 Visit = 8 hours maximum per visit. Precertification Required.	20% Coinsurance after Deductible		40% Coinsurance after Deductible
Respite Care	Not Covered		Not Covered
Retail Health Clinics	\$20 copay / per visit		40% Coinsurance after Deductible
Sterilization – Men are covered at Deductible and coinsurance. Woman are covered 100% per ACA.	Professional Non-Facility based Services: 20% Coinsurance after Deductible	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Sterilization Reversals	Not Covered		Not Covered
TMJ Treatment & Appliances Covered for medical treatment (surgical and non-surgical) Appliances are covered.	All Settings: 20% Coinsurance after deductible <i>Savings Plus Plan Benefit</i>		40% Coinsurance after Deductible
Vision Exams (Routine) and Hardware	Not Covered		Not Covered
Vision surgery – Cataract and Glaucoma - Glasses/Contacts after Cataract Surgery covered at 100%. Limited to 1 occurrence: includes initial frames, lenses or contact following cataract surgery.	Professional Non-Facility based Services: Non-specialist: \$20 copay / per visit Specialist: \$20 copay / per visit	Facility based Services: 20% Coinsurance after Deductible <i>Savings Plus Plan Benefit</i>	40% Coinsurance after Deductible
Wigs – After Chemotherapy. Covered if hair loss is a result of chemotherapy or radiation.	20% Coinsurance after Deductible		40% Coinsurance after Deductible
Transplant Services Centers of Excellence Locations Only			
Benefit	In-Network	Out-Of-Network	
Live Donor Health Services	20% Coinsurance after Deductible	Not Covered	
Bone Marrow Donor Search	20% Coinsurance after Deductible	Not Covered	
Organ Transplant – Facility Precertification Required	20% Coinsurance after Deductible	Not Covered	
Organ Transplant – Physician & anesthesiologist	20% Coinsurance after Deductible	Not Covered	
Travel and lodging for Organ Transplant - Precertification required.	Maximum reimbursement is \$10,000 per transplant.		

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Prescription Drug Benefits Carelon Rx 1-833-271-2374 or www.Carelonrx.com		
Generic (Tier 1)	No cost for Preventive Rx Drugs \$20 copay – Retail 30-day supply \$40 copay - Mail Order up to 90-day supply	Not Covered
Preferred (Tier 2)	\$30 copay – Retail 30-day supply \$60 copay - Mail Order up to 90-day supply	Not Covered
Non-Limited/Non-Preferred (Tier 3)	\$60 copay – Retail 30-day supply: \$120 copay - Mail Order up to 90-day supply	Not Covered
Specialty (Tier 4)	\$60 copay – Retail 30-day supply: N/A - Mail Order up to 90-day supply	Not Covered
Preauthorization (Health Link: 1-877-284-0102) The following services require Preauthorization, or benefit will be reduced by \$400 per occurrence.		
Inpatient Services:	Outpatient Services:	Other Services:
Cervical Spine Surgery	Diagnostic Imaging – Ambulatory: (Contact AIM for Review)	Ancillary Services:
Computer Navigation for Orthopedic Surgery	Coronary CT Angiography (CCTA)	Air Ambulance – Non-Emergent
Elective Admissions	Coronary MRA	Botulinum Toxin – Review for Migraine Use Only
Hospice	Cardiac MRI	Dialysis
LTAC Admissions	MRA of the Head and/or Neck	Home Health Services
Lumbar Spine Surgery	MRI of the Brain	Genetic Testing for Breast and/or Ovarian Cancer Syndrome
Oral Surgery	MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral	Genetic Testing for Inherited Peripheral Neuropathies
OB Delivery stays beyond the Federal Mandate minimum (including newborn stays beyond mother's stay)	PET Scan	Genetic Testing for PTEN Hamartoma Tumor Syndrome
Organ Transplants	Surgical Procedures – Ambulatory:	Home Hospice
Rehabilitation Facility Admissions	Blepharoplasty/Blepharoptosis	Home Infusion Services
Sacroiliac Joint Fusion	Bone-Anchored Hearing Aids	Home Health Care
Skilled Nursing Facility Admissions	Breast Procedures	Hospice
Managed Care Services:	Cardiac Resynchronization Therapy (CRT) with or without Implantable Cardioverter Defibrillator (CRT/ICD) for Treatment of Heart Failure	Hyperbaric Oxygen Therapy (Systemic/Topical)
Anesthesia	Cartilage Transplant Knee	Injections
Applied Behavior Analysis (ABA)	Cervical Spine Surgery	Occupational Therapy
Chemotherapy	Cochlear Implant	Orthotics and Prosthetic Devices
Inpatient BH/SA	Computer Navigation for Orthopedic Surgery	Physical Therapy
Electric Convulsive Therapy (ECT)	Cosmetic and Reconstructive Services of Head, Neck, Trunk and Groin	Private Duty Nursing
Intensive Outpatient Therapy	Elective Total Hip Arthroplasty	Speech Therapy
Partial Hospitalization (PHO)	Elective Total Knee Arthroplasty	
Residential Care (RTC)	IDET Procedure	Durable Medical Equipment:
Psychological testing	Implantable Cardioverter-Defibrillator (ICD)	Any DME equipment in excess of \$1,000 purchase price

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Genetic Counseling	Lumbar Spine Surgery	Bone Stimulator
	Mandibular/Maxillary Surgery (Orthognathic)	Cardio/External Defibrillator
	Mastectomy for Gynecomastia	Cooling Devices
	Nasal Septoplasty	CPAP/BIPAP
	Panniculectomy and Lipectomy/Diastasis Recti Repair	Electric Scooters
	Rhinoplasty	Infusion Pumps/Infusion Therapy
	Sacroiliac Joint Fusion	Insulin Pumps
	Sinus Endoscopy	Limb Prosthetics
	Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty	LVAD – Reviewed by Transplant
	Treatment of Varicose Veins (Lower Extremities)	Medical Supplies
	Travel and lodging (organ transplants)	Myoelectric prosthetics
		Neuromuscular Stimulators
		TENS Unit
		Wheelchairs (Custom or Power)
		Wound Vacs
Exclusions		
In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan		
Acupuncture – non-anesthetic (routine)	Hearing Aids	
Alternative Medicine/homeopathy	In-vitro Fertilization and Artificial Insemination	
Aquatic Therapy	Long-Term Care	
Arch supports (supportive shoe inserts)	Massage Therapy	
Bariatric Surgery	Maternity Care for dependent daughters	
Biofeedback	Methadone Clinics	
Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy)	Non-Emergency Care outside the U.S.	
Custodial Care	Non-Emergency use of Emergency room/Emergency services	
Dental Care (Routine) Adult and Child except ACA allowed	Orthopedic Shoes/ orthopedic inserts – Non-diabetic	
Developmental Delays	Reversal of sterilization	
Gene/ Cellular Therapy	Routine Eye Care (Adult) and Child except ACA allowed	
Genetic Testing (beyond PPACA mandate)	Self-Inflicted unless result of medical condition	
Growth Hormone Therapy	Vision Exam and Hardware	
Halfway house/home – non-healthcare residential facility	Wigs/Toupees (except if hair loss is a result of chemotherapy or radiation.)	