**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| Benefit | In-Network | Out-Of-Network |
|---|---|---|
| Plan Deductible | $3,500 Individual<br>$7,000 Family | $6,000 Individual<br>$12,000 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 | 15% | 30% |
| Out of Pocket Maximum | $6,000 Individual<br>$12,000 Family | $10,000 Individual<br>$20,000 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 |
| Calendar year | Calendar Year | 1/1 - 12/31 |

**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.**

**Preventive Medical Services**

| Benefit | In-Network | Out-Of-Network |
|---|---|---|
| Primary Care Physician Office:<br>Adult Routine Physical - 1 visit per calendar year. | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Pediatrician - Well Child Care:<br>Up to age 2 - 9 visits per calendar year<br>Age 2 – 2 visits per calendar year<br>Age 3 and more – 1 visit per calendar year | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Children Eye Exam | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Gynecological - Adult Routine Physical - 1 visit per calendar year. | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Maternity (ACA Required Prenatal /Postnatal Testing/Services only) | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Routine Immunizations (Child & Adult) | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Flu Shot (Routine) | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| X-Rays and Lab tests (Routine) | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Mammography (Routine) – 1 per calendar year; Age 40 and more | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Pap-smear (Routine) – 1 per calendar year | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Prostate Cancer Screening PSA (Routine) - 1 per calendar year | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |
| Colon Cancer Screening (Routine)<br>ages 45-75<br>Colonoscopy – 1 in 10 years<br>Sigmoidoscopy – 1 in 3 years | No Charge (Deductible Waived) | 30% Coinsurance after Deductible |

**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| **Non-Preventive Medical Services** | | | |
|---|---|---|---|
| **Providers cannot buy and bill as specialty medications/drugs are excluded.** The member may contact Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F. | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Primary Care Physician Visits | **Professional Non-Facility based Services:** $25 copay/visit | **Facility based Services:** $25 copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Specialist Physician Visits | **Professional Non-Facility based Services:** $50 copay/visit | **Facility based Services:** $50 copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Maternity Professional: Maternity Care for Dependent Child is excluded. | **Professional Non-Facility based Services:** No charge | **Facility based Services:** No Charge *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Chiropractic Care – Limited to 20 visits per calendar year | **Professional Non-Facility based Services:** $25 copay/visit | **Facility based Services:** $25 copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| **Non-Preventive Lab and Radiology** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Lab and Pathology | **Office Setting or Independent Lab** $25 copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| X-Rays / Radiology | **Office Setting or Independent Lab** $25 copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| MRI / MRA; CT / CTA / PET Scan: Genetic testing and counseling beyond ACA mandated is covered. | **Office Setting or Independent Lab** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Sleep Studies/Sleep Management Services | **All Settings:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| **Inpatient Services** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Pre-Surgical / Pre-Admission Testing | 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Maternity Care for dependent child is excluded. Inpatient Lab Maternity – newborn under mother for well-baby; Preauthorization is required; | 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Inpatient Physician Services | 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Inpatient Maternity Professional | 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |

**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| | | | |
|---|---|---|---|
| Anesthesia | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Inpatient Surgery- Surgeon/ Assistant Surgeon Charges | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Inpatient Detoxification: 24 hour withdrawal management is excluded. Preauthorization is required | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Inpatient Physical Medical Rehab – Limited to 60 days per calendar year. (Combined limit with Skilled Nursing Facility) | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Skilled Nursing Facility - Limited to 60 days per calendar year. (Combined limit with physical medical rehab) | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| **Outpatient Services** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Outpatient Surgery Facility Preauthorization is required. | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Outpatient Surgery -Physician / Surgeon / Assistant Surgeon | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Anesthesia | 15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Second Opinion – Surgical | **Professional Non-Facility based Services:**<br>Non-Specialist:<br>$25 copay/visit<br>Specialist: $50 copay/visit | **Facility based Services:**<br>Non-Specialist:<br>$25 copay/visit<br>Specialist:<br>$50 copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Home Health Care - Limited to 60 visits per calendar year. Visit limit is combined In and Out of Network. Patient is not required to be homebound. Not combined with home infusion limits. 1 visit = 4 hours. Home Health Aides are covered. | 15% Coinsurance after Deductible | | 30% Coinsurance after Deductible |
| Hospice – Facility or Home | **Home Setting:**<br>15% Coinsurance after Deductible | **Facility Setting:**<br>15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Behavioral/Mental Health & Chemical / Substance or Alcohol Abuse - Medication Management, Psych testing, Eating disorders, Partial Hospitalization, and Intensive Outpatient Therapy are covered. Methadone clinics and Halfway Homes are excluded. | **Professional Non-Facility based Services:**<br>$25 Copay/visit | **Facility based Services:**<br>$25 Copay/visit<br>*Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |

**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| Therapy Services | | | |
|---|---|---|---|
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Autism Spectrum Disorder – ABA Therapy is included Developmental delays are excluded | **Professional Non-Facility based Services:** $25 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Aural Therapy – post cochlear implantation | **Professional Non-Facility based Services:** $50 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Cardiac Rehabilitation – Limited to 36 visit per calendar year. Combined INN/OON visit limit. | **Professional Non-Facility based Services:** $50 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Chemotherapy | **Professional Non-Facility based Services:** $50 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Cognitive Therapy - Limited to 20 visit per calendar year. Combined INN/OON visit limit. | **Professional Non-Facility based Services:** $50 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Dialysis / Hemodialysis Home Dialysis is excluded. | **Outpatient Facility, Dialysis Center, Office Setting:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Gene/Cellular Therapy | 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Home Infusion | $50 Copay/visit *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Home visits – Professional | 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Infusion Therapy (**Provider can buy and bill)** | **Professional Non-Facility based Services:** $50 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Medical Nutrition Therapy | **Professional Non-Facility based Services:** Non-Specialist: $25 copay/visit Specialist: $50 copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Occupational Therapy - Limited to 60 visits per calendar year. Combined limit with Physical and Speech Therapy. Combined INN/OON visit limit. | **Professional Non-Facility based Services:** $25 Copay/visit | **Facility based Services:** $25 Copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Orthoptic / Pleoptic Therapy | Not Covered | Not Covered | Not Covered |
| Physical Therapy - Limited to 60 visits per calendar year. Combined limit with Occupational and Speech Therapy. Combined INN/OON visit limit. | **Professional Non-Facility based Services:** $25 Copay/visit | **Facility based Services:** $25 Copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |

**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| | | | |
|---|---|---|---|
| Pulmonary/Respiratory Therapy – Limited to 30 visit per calendar year. Combined INN/OON visit limit. | **Professional Non-Facility based Services:** $50 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Radiation Therapy | **Professional Non-Facility based Services:** $50 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Speech Therapy - Limited to 60 visits per calendar year. Combined limit with Occupational and Physical Therapy. Combined INN/OON visit limit. | **Professional Non-Facility based Services:** $25 Copay/visit | **Facility based Services:** $25 Copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| **Emergency Services** | | | |
| **Benefit** | **In-Network & Out-Of-Network** | | |
| Emergency Care | $250 Copay/visit (Deductible Waived) *Savings Plus Plan Benefit* | | |
| Urgent Care | $50 Copay/visit (Deductible waived) | 30% Coinsurance after Deductible | |
| Emergency Medical: Transportation: Ground, Air, are covered. Water Transport is not covered. | 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | |
| **Other Services** | | | |
| **Benefit** | **In-Network** | | **Out-Of-Network** |
| Abortion - Therapeutic and elective. Maternity Care for Dependent child is excluded. | **Professional Non-Facility based Services:** 15% Coinsurance after Deductible | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Acupuncture. | Not Covered | Not Covered | Not Covered |
| Allergy Services / Injections | **Professional Non-Facility based Services:** $50 Copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Allergy Testing | **Office Setting or Independent Lab** $25 copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Alternative Medicine | Not Covered | | Not Covered |
| Ambulance Service – Non Emergency Transport – Ground only. | 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | | 30% Coinsurance after Deductible |
| Bariatric Surgery | Not Covered | | Not Covered |
| Bereavement counseling | **Professional Non-Facility based Services:** $25 Copay/visit | **Facility based Services:** $25 Copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Biofeedback | Not Covered | | Not Covered |
| Blood Processing/Blood Storage: including autologous donation | 15% Coinsurance after Deductible | | 30% Coinsurance after Deductible |

**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| | | | |
|---|---|---|---|
| Dental – Accident to sound teeth only. Treatment must be started within 3 months of injury and completed within 12 months. Routine Dental is excluded. Dental Anesthesia is covered. | **Professional Non-Facility based Services:** 15% Coinsurance after Deductible | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. Breast Pumps are covered at 100%. Hospital grade pumps are excluded. Electric pumps – limited to 1 every 36 months. Manual pumps – limited to 1 every pregnancy | 15% Coinsurance after Deductible | | 30% Coinsurance after Deductible |
| Foot Care (routine) – Diabetic only. | **Professional Non-Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Gender Affirmation Treatment / Surgery | **Professional Non-Facility based Services:** Non-Specialist: $25 copay/visit Specialist: $50 copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Hearing Aids: (exams, fittings, and device) – Limited to 2 hearing aids (1 per ear) / every 24 months. In Network only. | 15% Coinsurance after Deductible | | Not Covered |
| Immunization – Non Routine: Vaccinations for travel are excluded | **Professional Non-Facility based Services: Non-Specialist:** $25 Copay/visit **Specialist:** $50 Copay/visit | **Facility based Services: Non-Specialist:** $25 Copay/visit **Specialist:** $50 Copay/visit *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Infertility Services - Basic Testing Only | **Office Setting or Independent Lab** $25 copay/visit | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF) Combined INN/OON with benefit limit of $2,000 per lifetime. | **Professional Non-Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Injections (**Provider can buy and bill)** | **Professional Non-Facility based Services:** 15% Coinsurance after Deductible | **Facility based Services:** 15% Coinsurance after Deductible *Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Medical Nutrition Products – PKU formulas and enteral feeding supplies | Not Covered | | Not Covered |

**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| | | | |
|---|---|---|---|
| Medical Supplies | **Professional Non-Facility based Services:**<br>Non-Specialist:<br>$25 copay/visit<br>Specialist: $50 copay/visit | **Facility based Services:**<br>15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Nutritional Counseling – Diabetic Or Non-Diabetic. | **Professional Non-Facility based Services:**<br>Non-Specialist:<br>$25 copay/visit<br>Specialist: $50 copay/visit | **Facility based Services:**<br>15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Online visits - Telephone consultations are excluded | $25 Copay/visit – Non-Specialist<br>$50 Copay/visit - Specialist | | 30% Coinsurance after Deductible |
| Oral Surgery: removal of impacted wisdom teeth is excluded. Oral surgery covered only for the treatment of congenital anomaly, traumatic injury, dislocations, tumors, cancer and obstructive sleep apnea | 15% Coinsurance after Deductible | | 30% Coinsurance after Deductible |
| Orthotics and Prosthetic Devices – Diabetic shoes are covered | 15% Coinsurance after Deductible | | 30% Coinsurance after Deductible |
| Private Duty Nursing | Not Covered | | Not Covered |
| Respite Care: Limited to 30 visits per calendar year. Combined INN/OON visit limit.<br>8 hours = 1 visit. | 15% Coinsurance after Deductible | | 30% Coinsurance after Deductible |
| Retail Health Clinics | Non-Specialist: $25 copay/visit<br>Specialist: $50 copay/visit | | 30% Coinsurance after Deductible |
| Sterilization – Men are covered at Deductible and coinsurance. Woman are covered 100% per ACA. | **Professional Non-Facility based Services:**<br>15% Coinsurance after Deductible | **Facility based Services:**<br>15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Sterilization Reversals | Not Covered | Not Covered | Not Covered |
| TMJ Treatment & Appliances | Not Covered | | Not Covered |
| Vision Exams (Routine) (Hardware excluded) All ages. Limited to 1 exam every 24 months. | **Professional Non-Facility based Services:**<br>$50 copay/visit | **Facility based Services:**<br>$50 copay/visit<br>*Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Vision surgery – Cataract and Glaucoma (includes initial frames, lenses or contact following cataract surgery) | **Professional Non-Facility based Services:**<br>15% Coinsurance after Deductible | **Facility based Services:**<br>15% Coinsurance after Deductible<br>*Savings Plus Plan Benefit* | 30% Coinsurance after Deductible |
| Wigs – Limited to $500 maximum benefit per calendar year. Combined maximum for INN/OON benefit. | 15% Coinsurance after Deductible | | 30% Coinsurance after Deductible |

**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| **Transplant Services**<br>**Centers of Excellence Locations Only** | | |
|---|---|---|
| **Benefit** | **In-Network** | **Out-Of-Network** |
| Live Donor Health Services | 15% Coinsurance after Deductible | Not Covered |
| Bone Marrow Donor Search – Limited to $10,000 Per calendar year | 15% Coinsurance after Deductible | Not Covered |
| Organ Transplant – Facility | 15% Coinsurance after Deductible | Not Covered |
| Organ Transplant – Physician & anesthesiologist | 15% Coinsurance 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 calendar year | |
| **Prescription Drug Benefits: Carelon Rx**<br>**1-833-261-22460 www.carelonrx.com** | | |
| Covers 30 day supply (retail), 31-90 day supply (retail or mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. | | |
| Generic (Tier 1) | **No cost for Preventive Rx Drugs**<br>**30 day supply:**<br>Lesser of cost of medication or $10.00 (deductible waived)<br>**31- 90 day supply:**<br>Lesser of cost of medication or $25.00 (deductible waived) | Not Covered |
| Preferred (Tier 2) | **30 day supply:** $25.00 copay (deductible waived)<br>**31- 90 day supply:**$50.00 copay (deductible waived) | Not Covered |
| Non-Limited/Non-Preferred (Tier 3) | **30 day supply:** $50.00 copay (deductible waived)<br>**31- 90 day supply** $125.00 copay (deductible waived) | Not Covered |
| Specialty (Tier 4) | All Specialty Drugs are Excluded: Contact Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F. | |
| **Preauthorization (Anthem UM/CM West: 1-800-274-7767)**<br>The following services require Preauthorization, or benefit will be reduced by $1,000 for inpatient stays or 20% for outpatient services. | | |
| **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 |

**Compunnel Inc.**
**Employee Benefit Summary – Gold PPO SPP**
**Network: National PPO (BlueCard PPO) Network**
**Effective Date: 05/01/2025**

| | | |
|---|---|---|
| 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 |
| 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

| | |
|---|---|
| 24 hour detoxification withdrawal management | Long term (more than 30 days) storage of blood, umbilical cord or other material. |
| Alternative Medicine/homeopathy | Massage Therapy |
| Aquatic Therapy | Maternity care for dependent child |
| Arch supports (supportive shoe inserts) | Methadone Clinics |
| Bariatric Surgery | Non-Emergency Care outside the U.S. |
| Biofeedback | Orthopedic Shoes/ orthopedic inserts – Non-diabetic |
| Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy) | Self-Inflicted unless result of medical condition |
| Custodial Care | Sterilization Reversals |
| Dental Care (Routine) Adult and Child except ACA allowed | TMJ Treatment and Appliances |
| Growth Hormone Therapy | Vision Hardware – except post cataract surgery |
| Halfway house / Home – (Non-healthcare residential facility) | Weight Loss Programs |
| Long-Term Care | |