2023 Schedule of Benefits – Centivo Platinum Plus EPO

This *Schedule of Benefits* describes the coverage for the Centivo Platinum Plus EPO. Please note that this coverage option is currently administered by Centivo (medical & behavioral health). **This Schedule of Benefits is to be read in conjunction with your Summary Plan Description which provides additional information regarding your rights under the Plan.**

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible		
Individual Deductible	$0	Not Applicable
Family Deductible	$0	Not Applicable
Maximum Out of Pocket Limit*		
Individual (Medical)	$2,500	Not Applicable
Family (Medical)	$5,000	Not Applicable

**The Maximum Out-of-Pocket Limit includes all medical and pharmacy copayments. The Maximum Out-of-Pocket Limit is the maximum amount you are responsible to pay for covered expenses during the calendar year. Once you satisfy the applicable Maximum Out-of-Pocket Limit, the plan will pay 100% of the covered medical and pharmacy expenses that apply toward the limit for the rest of the calendar year for in-network provider services, as applicable. This plan offers an "embedded" individual Out-of-Pocket Limit. For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit. There is no maximum Out-of-Pocket limit on out-of-network services.*

Under the Centivo Platinum Plus plan, you must choose a Primary Care Provider before going to the doctor. If you don't activate, your care will not be covered (except for OB/GYN, behavioral health, and emergencies). You can make your PCP selection on the app, at https://my.centivo.com, or by calling into Centivo Member Care 1 (833) 666-1302.

When you need care outside of your Primary Care Provider, your care team will act as a gateway to specialist care, referring you to the right places to make sure you get high-quality

care and keeping you in-network for lower costs. This plan requires PCP-coordinated specialty referrals, or claims will not be paid.

It is your responsibility as the member to make sure that your Primary Care Team has submitted your referral, prior to receiving care. Referrals can be viewed once you register on the Centivo app, or through https://my.centivo.com.

You do not need a PCP referral for the following visit types, but you must stay within the Centivo network to receive plan benefits:

- *Urgent care visits*
- *ER visits*
- *Hospital admissions –but you must report your care to Centivo within 72 hours of admission*
- *OB/GYN visits*
- *Visits with behavioral or substance use disorder health providers*
- *Laboratory tests, x-rays, acupuncture, chiropractic, or therapies (occupational, physical, or speech) –but a physician must order or prescribe these services*

<u>Expenses That Do Not Apply to the Maximum Out-of-Pocket Limit</u>
Certain covered expenses do not apply toward your Maximum Out-of-Pocket Limit. These include:

- *Charges over the recognized charge;*
- *Non-covered expenses; Expenses for non-emergency use of the emergency room; Expenses incurred for non-urgent use of an urgent care provider;*
- *Expenses that are not paid because they are plan exclusions, or did not meet medical necessity criteria. or pre-certification benefit reductions, because a required pre-certification for the service(s) or supply was not obtained from your medical plan administrator;*
- *Non-emergent, elective services that are provided by a non-network provider without prior authorization from Centivo*

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum Benefit per person	Unlimited	Not applicable

Percentages listed in the Schedule below reflect the coinsurance percentage that the plan pays. You are responsible to pay any deductibles and remaining percentage. You are responsible for full payment of any non-covered expenses you incur.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams **Office Visits**	100% per visit No copay	Not Covered

Maximum exams per calendar year: *Covered Persons under age 2* *Covered Persons age 2-3* *Covered Persons age 3 and over*	 Unlimited 2 exams 1 exam	 Not Covered Not Covered Not Covered
Preventive Care Immunizations *Performed in a facility or physician's office*	100% per visit No copay	Not Covered
Screening & Counseling Services- *Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products* Obesity: Misuse of Alcohol and/or Drugs: Use of Tobacco Products: Maximum visits per calendar year:	100% per visit No copay Unlimited visits Unlimited visits Unlimited visits	Not Covered Not Covered Not Covered Not Covered
Well Woman Preventive Visits *Performed in a facility or physician's office* Maximum visits per calendar year:	100% per visit No copay or deductible applies 1 visit	Not Covered Not Covered
Hearing Evaluations	$0 copay primary care physician; $40 copay specialist	Not Covered

Hearing Aids Maximum supply every 3 years:	1 hearing aid per ear, up to $1,500 total maximum	Not Covered
Routine Cancer Screening-Outpatient Maximums: *For details, contact your physician, log onto your medical plan administrator's website or call the number on the back of your ID card.*	100% per visit No copay Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration	Not Covered Not Covered
Prenatal Care Office Visits	Initial visit - $0 copay Primary Care Physician; $40 copay specialist Subsequent visits - 100% covered	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Preventive Care Benefits (continued…)		
Comprehensive Lactation Support and Counseling Services-Facility or Office Visits <u>Lactation Counseling Services</u> Maximum visits either in a group or individual setting	100% per visit No copay 6* visits per 12 months	Not Covered Not Covered
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Breast Pumps and Supplies*	100% per visit No copay	Not Covered
***Important Note**: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.		

Family Planning Services- Office Visits		
Female Contraceptive Counseling Services	100% per visit No copay	Not Covered
Maximum visits either in a group or individual setting	2* visits per 12 months	N/A
***Important Note:** Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.*		
Family Planning- Other		
Voluntary or Therapeutic Termination of Pregnancy-Outpatient	100% covered after $40 Specialist copay 100% covered after $300 out-patient facility copay	Not Covered
Voluntary Sterilization for Males- Outpatient	$0 copay primary care physician; 100% covered after $40 copay specialist;	Not Covered
Voluntary Sterilization for Females- Inpatient	100% per visit No copay	Not Covered
Voluntary Sterilization for Females- Outpatient	100% per visit No copay	Not Covered
Family Planning- Female Contraceptives		
Female Contraceptive-Generic Prescription Drugs *(associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)*	100% per prescription or refill (covered through CVS) No deductible applies	Not Covered
Female Contraceptive-	100% per prescription or refill	Not Covered

Devices

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits- Non-Surgical		
Primary Care Physician (PCP)	$0 copay	Not Covered
Specialist	$40 copay	Not Covered
Physician Office Visits- Surgical		
Primary Care Physician (PCP)	100% covered, no copay	Not Covered
Specialist	100% covered after $40 Specialist copay	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Physician Services (continued…)		
Physician Services- Inpatient- Facility and Hospital Visits	100% Covered	Not Covered
Administration of Anesthesia	100% Covered	Not Covered
Allergy Tests and Treatments	100% covered primary care physician; 100% covered after $40 copay specialist	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Emergency Room	$250 copay Waived if admitted	$250 copay

Please note that out-of-network providers do not have a contract with your plan's administrator, the provider may not accept payment of your cost share (your copay), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send your administrator the bill at the address listed on the back of your member ID card and they will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.		
Ambulance Services	100% covered	100% covered
Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered

PLAN FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Services		
Urgent Medical Care- At a non-hospital free standing facility	$100 copay	$100 copay
From other than a non-hospital free standing facility	Refer to *Emergency Medical Services* and *Physician Services* above	N/A
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

PLAN FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging	$100 copay	Not Covered
Diagnostic Laboratory Testing	100% covered	Not Covered
Diagnostic X-Rays *Except Complex Imaging Services*	100% covered	Not Covered

PLAN FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Surgery		

Outpatient Surgery	Office Visit: 100% covered in PCP office	Not Covered
	100% covered after $40 copay in Specialty office	Not Covered
	$300 copay per admit to Out-patient or Ambulatory Surgical Center	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	$500 copay	Not Covered
Hospital Facility Expenses		Not applicable
Room and Board *Including maternity*	$500 copay	Not Covered
Other than Room and Board	100% covered after $500 copay	Not Covered
Skilled Nursing Inpatient Facility	$500 copay	Not Covered
Maximum days per calendar year:	120 days	Not applicable

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care-Outpatient	$40 copay/visit	Not Covered
Maximum visits per calendar year: *1 visit = 4 hours maximum*	40 visits	Not applicable
Private Duty Nursing-Outpatient	$40 copay	Not Covered

Maximum visits per calendar year:	70 Private Duty Nursing Shifts Up to 8 hours will be deemed to be one private duty nursing shift	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Hospice Benefits		
Hospice Care-Facility Expenses		
Room and Board	$500 copay per admit	Not Covered
Other Expenses During a Stay	100% covered	Not Covered
Maximum benefit per lifetime	Unlimited days	Not applicable
Outpatient Hospice	$300 copay per admit	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered
Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only		

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Obesity Treatment-Non-Surgical		

Outpatient Obesity Treatment-Non-Surgical	Office Visit: 100% covered in PCP office $40 copay in Specialty office	Not Covered

PLAN FEATURES	IN-NETWORK *Designated Facility*	OUT-OF-NETWORK *Non-Designated Facility OR Out-Of-Network Facility*
Obesity Treatment-Surgical		
Morbid Obesity Surgery-Inpatient Includes Surgical procedure and Acute Hospital Services	$500 copay Precertification required	Not Covered
Morbid Obesity Surgery-Outpatient Includes Surgical procedure and Acute Hospital Services	$300 copay Precertification required	Not Covered
Maximum benefit: Inpatient & Outpatient	Unlimited	Not Covered

PLAN FEATURES	IN-NETWORK *Designated Facility*	IN-NETWORK *Non-Designated Facility*	*Out-Of-Network*
Transplant Services-Facility and Non-Facility Expenses			
Transplant Facility Expenses	$500 per in-patient admission $300 per out-patient admission	Not Covered	Not Covered
Transplant Physicians Services Including Office Visits	$40 specialty office visit copay In-patient and out-patient surgical fees covered at 100%	Not Covered	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	$40 copay. 20 visits per calendar year	Not Covered
Ground, Air or Water Ambulance	100% Covered No copay	100% Covered No copay*
Please note that out-of-network providers do not have a contract with your plan's administrator, the provider may not accept payment of your cost share (your copay), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send your administrator the bill at the address listed on the back of your member ID card and they will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.		
Durable Medical and Surgical Equipment	100% Covered No copay	Not Covered
Oral and Maxillofacial Treatment- Mouth, Jaws and Teeth	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered
Prosthetic Devices	100% Covered No copay	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	100% Covered No copay	Not Covered
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered
Radiation Therapy	100% Covered No copay	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK

Short-Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupation, and Speech Therapy combined	$0 copay primary care physician; $40 copay specialist	Not Covered

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
Spinal Manipulation	$0 copay primary care physician; $40 copay specialist	Not Covered
Maximum visits per year:	30 visits	Not applicable

Mental Health and Substance Use Disorder

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Office and Outpatient Services		
Office Visit	No charge	Not covered
Outpatient Facility Based Therapies	$300 copay	Not covered
Autism Applied Behavioral Analysis (ABA)- *Pre-certification required*	No charge	Not covered
Outpatient Psychiatric Testing *Pre-certification required*	No charge in provider's office $300 per admit Outpatient facility	Not covered

Transcranial Magnetic Stimulant (TMS) *Pre-certification required*	No charge in provider's office after $40 specialty copay $300 per admit Outpatient facility	Not covered
Laboratory Testing	100% covered, no copay	Not covered

PLAN FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient and Alternative Levels of Care *Notification/Pre-certification Required*		
Inpatient Coverage *Pre-certification required*	$500 copay	Not covered
Detox and Rehab Inpatient Coverage *Pre-certification required*	$500 copay	Not covered
Residential Treatment Center Coverage *Pre-certification required*	$500 copay	Not covered
Partial Hospital Program (PHP) **Intensive Outpatient Program (IOP- 9 hours per week)** **Group Home Coverage** *Pre-certification required*	$300 copay	Not covered
Inpatient Psychiatric Testing *Pre-certification required*	$500 copay per admit, Testing is covered at 100% no copay	Not covered
	$500 copay per admit	Not covered

Inpatient Electroconvulsive Therapy (ECT)- Facility and Physicians Charges *Pre-certification required*	Physician charges covered at 100% no copay	
Inpatient Electroconvulsive Therapy (ECT)- Anesthesia Charges *Pre-certification required*	100% covered	Not covered
Inpatient Laboratory Testing *Pre-certification of inpatient hospital stay required to allow for testing*	100% covered for testing during an inpatient stay $500 copay per admit applies	Not covered

NOTE: THE CHART ABOVE MUST BE READ IN CONJUNCTION WITH THE PROVISIONS BELOW.

(In case you need this for any other document referencing the RX plan):

Covered prescription drug expenses	**Participating Pharmacy[1]**	**Non-Participating Pharmacy**	**LIMITS[2]**
Routine preventive drugs required by the Affordable Care Act	100% Covered	Not Covered	
Retail Pharmacy (30-day supply)			CVS Pharmacy 1.844.635.3401
Tier One **Generic prescription or refill**	100% Covered No Copay	Not Covered	See Prescription Drug Benefits section

Tier Two **Formulary Brand prescription or refill**	$25 Copay	Not Covered	See Prescription Drug Benefits section
Tier Three **Non-Formulary/non-preferred prescription or refill**	$150 Copay	Not Covered	See Prescription Drug Benefits section
Mail Order Option - (90 day supply)			
Tier one **Generic prescription or refill**	100% Covered No Copay	Not Covered	See Prescription Drug Benefits section
Tier Two **Formulary Brand Name prescription or refill**	$50 Copay	Not Covered	See Prescription Drug Benefits section
Tier Three **Non-Formulary/Non-preferred prescription or refill**	$300 Copay	Not Covered	See Prescription Drug Benefits section

Covered Expenses

General Rules

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

- Be included as a covered expense in this Schedule;

▪ Not be an excluded expense listed in this Schedule. Refer to the *Exclusions* sections below for a list of services and supplies that are excluded;

▪ Not exceed the maximums and limitations outlined in the chart above or the descriptions below; and

▪ Be obtained in accordance with all the terms, policies and procedures outlined in the Plan, the SPD, and this Schedule (including Pre-certification, if applicable).

2. The service or supply must be provided while coverage is in effect.

3. The service or supply must be medically necessary. To meet this requirement, the medical services or supply must be provided by a physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

(c) Not primarily for the convenience of the patient, physician or other health care provider;

(d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Important Note about Medical Necessity:

Not every service or supply that fits the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical or mental health & substance use disorder services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum.

Pre-certification

Certain services, such as inpatient stays, certain tests, procedures and outpatient surgery require pre-certification by the Plan. Pre-certification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows the Plan to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

-The Pre-certification Process-

Prior to being hospitalized or receiving certain other medical services or supplies there are certain pre-certification procedures that must be followed. You or a member of your family, a hospital staff member, or the attending physician, must notify the Plan through your medical or mental health & substance use disorder plan administrator to pre-certify the admission, medical or mental health & substance use disorder services and expenses prior to receiving any of the services or supplies that require pre-certification pursuant to this *Schedule* in accordance with the following timelines:

Pre-certification should be secured within the timeframes specified below. To obtain pre-certification, call your medical plan administrator at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your physician or the facility will need to call and request pre-certification at least 14 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.
For outpatient non-emergency medical or mental health & substance use disorder services requiring pre-certification:	You or your physician must call at least 7 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Your medical or mental health & substance use disorder plan administrator will provide a written notification to you and your physician of the pre-certification decision. If your Pre-certified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, your medical or mental health & substance use disorder plan administrator will notify you, your physician and the facility about your pre-certified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician, or the facility will need to call your medical or mental health & substance use disorder plan administrator at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Your medical or mental health & substance use disorder plan administrator will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If pre-certification determines that the stay or services and supplies are Not Covered expenses, the notification will explain why and how the Plan's decision can be appealed.

Services and Supplies Which Require Pre-certification

Pre-certification is required as specified in this *Schedule*, including for the following types of medical expenses:

- Stays in a hospital
- Stays in a skilled nursing facility

- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a residential treatment facility (including wilderness camps and similar programs) for treatment of mental disorders, alcoholism or drug abuse treatment
- Home health care
- Private duty nursing care
- Psychiatric Testing
- Electroconvulsive-therapy (ECT)
- Applied Behavioral Analysis (ABA) Treatment for Autism Spectrum Disorder
- Outpatient Surgeries not done in a doctor's office
- MRI/CT/PET Scans (excludes bone density studies)
- Electron Beam Tomography
- Physicial/Occupational/Speech Therapy beyond 12 visits
- DME over $2,500

One reason pre-certification is required is that not all facilities meet the Plan's accrediting standards. Pre-certification ensures that you are accessing a properly accredited facility that provides appropriate treatment so that you are eligible for benefits.

-How Failure to Pre-certify Affects Your Benefits-

A pre-certification benefit reduction will be applied to the benefits paid if you fail to obtain a required

Pre-certification prior to incurring medical expenses. This means the amount paid towards your coverage will be reduced, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary pre-certification from the Plan through your medical or mental health & substance use disorder plan administrator prior to receiving services from an out-of-network provider. Your provider may pre-certify your treatment for you; however you should verify with your medical or mental health & substance use disorder plan administrator prior to the procedure, that the provider has obtained pre-certification from your medical plan administrator. If your treatment is not pre-certified by you or your provider, the benefit payable may be significantly reduced or the plan may not pay any benefits.

-How Your Benefits are Affected-

The chart below illustrates the effect on your benefits if necessary pre-certification is not obtained.

If pre-certification is:	then the expenses are:
▪ requested and approved by your medical or mental health & substance use disorder plan administrator.	▪ covered.
▪ requested and denied.	▪ Not Covered, may be appealed.
▪ not requested, but would have been covered if requested.	▪ covered after retrospective review on appeal

▪ not requested, but would not have been covered if requested.	▪ Not Covered, may be appealed.

• Preventive Care

-Routine Physical Exams-

Covered expenses include charges made by your physician for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

- Screening and counseling services, such as:

  ▫ Interpersonal and domestic violence;

  ▫ Sexually transmitted diseases; and

  ▫ Human Immune Deficiency Virus (HIV) infections.

- Screening for gestational diabetes; and

- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.

• X-rays, lab and other tests given in connection with the exam.

• For covered newborns, an initial hospital checkup.

Limitations:

Unless specified above, **Not Covered** under this *Preventive Care* benefit are charges for:

• Services which are covered to any extent under any other part of this Plan;

• Services which are for diagnosis or treatment of a suspected or identified illness or injury;

• Exams given during your stay for medical care;

• Services not given by a physician or under his or her direction;

• Psychiatric, psychological, personality or emotional testing or exams.

-Preventive Care Immunizations-

Covered expenses include charges made by your physician or a facility for immunizations for infectious diseases (including the materials for administration of immunizations) that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Limitations:

Not Covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care such as those required due to your employment or travel.

-Well Woman Preventive Visits-

Covered expenses include charges made by your physician for a routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

Limitations:

Unless specified above, **Not Covered** under this *Preventive Care* benefit are charges for:

• Services which are covered to any extent under any other part of this Plan;

• Services which are for diagnosis or treatment of a suspected or identified illness or injury;

• Exams given during your stay for medical care;

• Services not given by a physician or under his or her direction;

• Psychiatric, psychological, personality or emotional testing or exams.

-Routine Cancer Screenings-

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and

- Colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines that are:

▪ Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and

▪ Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges incurred for services which are covered to any extent under any other part of this Plan. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your physician**,** call your Accolade Health Assistant, log onto your medical plan administrator's website, or call your medical plan administrator's Customer Service.

-Screening and Counseling Services-

Covered expenses include charges made by your physician in an individual or group setting for the following:

-Obesity-

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- preventive counseling visits and/or risk factor reduction intervention;
- medical nutrition therapy;
- nutrition counseling; and
- healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

-Misuse of Alcohol and/or Drugs-

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

-Use of Tobacco Products-

Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff;

smokeless tobacco and candy-like products that contain tobacco. Coverage includes preventive counseling visits, treatment visits, and class visits to aid in the cessation of the use of tobacco products.

Limitations:
Unless specified above, **Not Covered** under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

-Prenatal Care-Prenatal care will be covered as Preventive Care for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Limitations:

Unless specified above, **Not Covered** under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan; and
- Pregnancy expenses (other than prenatal care as described above).

-Comprehensive Lactation Support and Counseling Services-

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post-partum period by a certified lactation support provider. The "post-partum period" means the one-year period directly following the child's date of birth. Covered expenses incurred during the post-partum period also include the rental or purchase of breast feeding equipment as described below. Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting.

-Breast Feeding Durable Medical Equipment-

Coverage includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows.

-Breast Pump-

Covered expenses include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
  - A manual breast pump. A purchase will be covered once every three years.
- If an electric breast pump was purchased within the previous three year period, the purchase of an electric or manual breast pump will not be covered until a three year period has elapsed from the last purchase of an electric pump.

-Breast Pump Supplies-

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

The Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the Plan's discretion.

Limitations:

Unless specified above, **Not Covered** under this *Preventive Care* benefit are charges incurred for services which are covered to any extent under any other part of this Plan.

If a breast pump service or supply that you need is covered under this Plan but not available from a network provider in your area, please contact Member Services at the toll-free number on your ID card for assistance.

-Family Planning Services - Female Contraceptives-

For females with reproductive capacity, covered expenses include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting.

The following contraceptive methods are **covered expenses** under this Preventive Care benefit:

-Voluntary Sterilization-

Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

-Contraceptives-

Covered expenses include charges made by a physician for:

- Female contraceptives that are brand name or generic prescription drugs;
- Female contraceptive devices including the related services and supplies needed to administer the device.

Limitations:

Unless specified above, **Not Covered** under this Preventive Care benefit are charges for:

• Services which are covered to any extent under any other part of this Plan;

• Services and supplies incurred for an abortion;

• Services which are for the treatment of an identified illness or injury;

• Services that are not given by a physician or under his or her direction;

• Psychiatric, psychological, personality or emotional testing or exams;

• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;

• Male contraceptive methods, sterilization procedures or devices;

• The reversal of voluntary sterilization procedures, including any related follow-up care.

-Family Planning Services – Other-

Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury.

- Voluntary sterilization for males;
- Voluntary termination of pregnancy.

Limitations:

Not Covered are:

▪ Reversal of voluntary sterilization procedures, including related follow-up care;

▪ Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer;

▪ Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

• Physician Services

-Physician Visits-

Covered medical expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility. Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the physician for supplies, radiological services, x-rays, and tests provided by the physician.

-Surgery-

Covered expenses include charges made by a physician for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another physician to obtain a second opinion prior to the surgery.

-Anesthetics-

Covered expenses include charges for the administration of anesthetics and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

-Alternatives to Physician Office Visits-

-Walk-In Clinic Visits-

Covered expenses include charges made by walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity;
  - in stress management. The stress management counseling sessions will help you to identify the life events which cause you stress (the physical and mental strain on your body.) The counseling sessions will teach you techniques and changes in behavior to reduce the stress.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges incurred for services and supplies furnished in a group setting for screening and counseling services. Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.

• Hospital Expenses

Covered medical expenses include services and supplies provided by a hospital during your stay.

-Room and Board-

Covered expenses include charges for room and board provided at a hospital during your stay. Private room charges that exceed the hospital's semi-private room rate are Not Covered unless a private room is required because of a contagious illness or immune system problem.

Room and board charges also include:

- Services of the hospital's nursing staff;

- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

-Other Hospital Services and Supplies-

Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay.

Covered expenses include hospital charges for other services and supplies provided, such as:

- Ambulance services.
- Physicians and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

-Outpatient Hospital Expenses-

Covered expenses include hospital charges made for covered services and supplies provided by the outpatient department of a hospital. The plan will only pay for nursing services provided by the hospital as part of its charge. The plan does **not cover** private duty nursing services as part of an inpatient hospital stay. If a hospital or other health care facility does not itemize specific room and board charges and other charges, the Plan will assume that 40 percent of the total is for room and board charge, and 60 percent is for other charges. In addition to charges made by the hospital, certain physicians and other providers may bill you separately during your stay.

-Coverage for Emergency Medical Conditions-

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

- Use of emergency room facilities;

- Emergency room physicians services;
- Hospital nursing staff services; and
- Radiologists and pathologists services.

Please contact your physician after receiving treatment for an emergency medical condition.

With the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan will **not cover** your expenses. No other plan benefits will pay for non-emergency care in the emergency room.

-Coverage for Urgent Conditions-

Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- Physicians services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your physician after receiving treatment of an urgent condition.

If you visit an urgent care provider for a non-urgent condition, the plan will **not cover** your expenses.

-Alternatives to Hospital Stays-

-Outpatient Surgery and Physician Surgical Services-

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A physician or dentist for professional services;
- A surgery center; or
- The outpatient department of a hospital.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital and
- The surgery is not normally performed in a physician's or dentist's office.

Benefits for surgery services performed in a physician's or dentist's office are described under Physician Services benefits in the previous section.

- The following outpatient surgery expenses are covered:
- Services and supplies provided by the hospital, surgery center on the day of the procedure;
- The operating physician's services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations:

Not Covered under this plan are charges made for:

- The services of a physician or other health care provider who renders technical assistance to the operating physician;

- A stay in a hospital;

- Facility charges for office based surgery.

-Birthing Center-

Covered expenses include charges made by a birthing center for services and supplies related to your care in a birthing center for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges in connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other covered expenses related to maternity care.

-Home Health Care-

Home health care requires pre-certification. Covered expenses include charges made by a home health care agency for home health care, and the care:

- Is given under a home health care plan;
- Is given to you in your home while you are homebound.

Home health care expenses include charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
- Medical supplies, prescription drugs and lab services by or for a home health care agency to the extent they would have been covered under this plan if you had a hospital stay.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit.

In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.

This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges for:

- Services or supplies that are not a part of the Home Health Care Plan.

- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.

- Services of a certified or licensed social worker.

- Services for physical, occupational and speech therapy.

- Services for Infusion Therapy.

▪ Transportation.

▪ Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.

▪ Services that are custodial care.

The plan does **not cover** custodial care, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

-Private Duty Nursing-

Covered expenses include private duty nursing provided by a R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a Calendar Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or emergency medical condition by a physician;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient stay.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges for:

▪ Nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.

▪ Nursing care assistance for daily life activities, such as:

- Transportation;
- Meal preparation;
- Vital sign charting;
- Companionship activities;
- Bathing;
- Feeding;
- Personal grooming;
- Dressing;
- Toileting; and
- Getting in/out of bed or a chair.

- Nursing care provided for skilled observation.

- Nursing care provided while you are an inpatient in a hospital or health care facility.

- A service provided solely to administer oral medicine, except where law requires a R.N. or L.P.N. to administer medicines.

-Skilled Nursing Facility-

Admission requires pre-certification. Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies:

- Room and board, up to the semi-private room rate. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services); and
- Medical supplies.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges for:

- Charges made for the treatment of:

  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and

- Daily room and board charges over the semi-private rate.

-Hospice Care-

Admission requires pre-certification. Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

-Facility Expenses-

The charges made by a hospital, hospice or skilled nursing facility for:

- Room and Board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

-Outpatient Hospice Expenses-

Covered expenses include charges made on an outpatient basis by a Hospice Care Agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a physician. These include but are not limited to:
    - Assessment of your social, emotional and medical needs, and your home and family situation;
    - Identification of available community resources; and
    - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a physician;
- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a Hospice Care Agency; and such Agency retains responsibility for your care:

- A physician for a consultation or case management;
- A physical or occupational therapist;
- A home health care agency for:
    - Physical and occupational therapy;
    - Part time or intermittent home health aide services for your care up to eight hours a day;
    - Medical supplies;
    - Prescription drugs;
    - Psychological counseling; and
    - Dietary counseling.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges for:

- Daily room and board charges over the semi-private room rate.

- Funeral arrangements.

- Pastoral counseling.

- Financial or legal counseling. This includes estate planning and the drafting of a will.

- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

• Other Covered Health Care Expenses

-Acupuncture-

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed as a form of anesthesia in connection with a covered surgical procedure.

-Ambulance Service-

Covered expenses include charges made by a professional ambulance, as follows:

-Ground Ambulance-

Covered expenses include charges for transportation:

- To the first hospital where treatment is given in a medical emergency.
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition.
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

-Air or Water Ambulance-

Covered expenses include charges for transportation to a hospital by air or water ambulance when:

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- Ground ambulance transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital; and the two conditions above are met.

Limitations:

Not Covered under this benefit are charges incurred to transport you:

- If an ambulance service is not required by your physical condition; or
- If the type of ambulance service provided is not required for your physical condition; or
- By any form of transportation other than a professional ambulance service.

-Autism Spectrum Disorder (ASD) Care Management-

Applied Behavior Analysis (ABA) Treatment for ASD

- Services provided by credential BCBAs and behavioral therapists (para-professionals)

-Diagnostic and Preoperative Testing-

-Diagnostic Complex Imaging Expenses-

The plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service costing over $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

***Limitations**:*

The plan does **not cover** diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

-Outpatient Diagnostic Lab Work and Radiological Services-

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiological facility or lab.

-Outpatient Preoperative Testing-

Prior to a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are covered expenses and the tests are:

- Related to your surgery, and the surgery takes place in a hospital or surgery center;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a hospital;
- Not repeated in or by the hospital or surgery center where the surgery will be performed.
- Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed.

Limitations:

The plan does **not cover** diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan. If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will **not** be covered.

Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply.

-Durable Medical and Surgical Equipment (DME)-

Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental:

The initial purchase of DME if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are Not Covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in the Exclusions section. The Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the Plan's discretion. Refer to *Exclusions* for information about Home and Mobility exclusions.

-Experimental or Investigational Treatment-

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures, provided **all** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- The Plan determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

Hospital means an institution determined by the Claims Administrator to be:

1. ***an institution that is licensed and operated in accordance with the laws of the jurisdiction in which it is located pertaining to hospitals that maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of Injury and Sickness and that provides such treatment for compensation by or under the supervision of Licensed Physicians on an inpatient basis with continuous 24-hour nursing service by Nurses;***

2. ***an institution that qualifies under Medicare as a hospital, a psychiatric hospital, or a tuberculosis hospital, that qualifies as a provider of services under Medicare, and that is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals;***

3. ***an institution that specializes in the treatment of Substance Abuse or Chemical Dependency, that provides residential treatment programs, that is licensed in accordance with the laws of the jurisdiction in which it is located by the appropriate legally authorized agency and that is approved under uniform criteria established by the Claims Administrator;***

4. ***holds an active accreditation from a nationally recognized accrediting body such as The Joint Commission (TJC), The Rehabilitation Accreditation Commission (CARF), and Council on Accreditation (COA), American Osteopathic Association (AOA), Healthcare Facilities Accreditation Program (HFAP), and Accreditation Association for Ambulatory Health Care (AAAHC), Det Norske Veritas (DNV) or Community Health Accreditation Program (CHAP)***

-Pregnancy Related Expenses-

Covered expenses include charges made by a physician for pregnancy and childbirth services and supplies at the same level as any illness or injury. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, covered expenses include charges made by a Hospital for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a birthing center as described under Alternatives to Hospital Care.

Covered expenses also include services and supplies provided for circumcision of the newborn during the stay.

-Prosthetic Devices-

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or

- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The Plan will **not cover** expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the *Exclusions* section.

-Hearing Aids-

Covered hearing care expenses include charges for electronic hearing aids (monaural and binaural), installed in accordance with a prescription written during a covered hearing exam.

-Benefits After Termination of Coverage-

Expenses incurred for hearing aids within 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if during the 30 days before the date coverage ends:

- The prescription for the hearing aid was written; and
- The hearing aid was ordered.

-Short-Term Rehabilitation Therapy Services-

Covered expenses include charges for short-term therapy services when prescribed by a physician as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A hospital, skilled nursing facility, or hospice facility;
- A home health care agency; or
- A physician.

Charges for the following short term rehabilitation expenses are covered:

-Cardiac and Pulmonary Rehabilitation Benefits-

- Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

-Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits-

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this *Schedule*.

- Physical therapy is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect

present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. Additional coverage for speech therapy is available for the treatment of Autism and developmental delays (as an exception to the above non-chronic condition coverage criteria).

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services provided in your home if you are homebound.

Limitations:

Unless specifically covered above, **Not Covered** under this benefit are charges for:

▪ Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are Not Covered. Examples of non-covered diagnoses include Down's syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This exclusion does not apply to speech therapy for the treatment of Autism or developmental delays;

▪ Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer;

▪ Any services unless provided in accordance with a specific treatment plan;

▪ Services for the treatment of delays in speech development, unless resulting from illness, injury, or congenital defect;

▪ Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;

▪ Services not performed by a physician or under the direct supervision of a physician;

▪ Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;

▪ Services provided by a physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;

▪ Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

-Reconstructive or Cosmetic Surgery and Supplies-

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when:
  - the defect results in severe facial disfigurement; or
  - the defect results in significant functional impairment and the surgery is needed to improve function

-Reconstructive Breast Surgery-

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

-Transgender Reassignment (Sex Change) Surgery-

Requires pre-certification. Covered expenses include charges in connection with a medically necessary Transgender Reassignment (sometimes called Sex Change) Surgery.

Covered expenses include:

▪ Charges made by a physician for:

- Performing the surgical procedure; and

• Pre-operative and post-operative hospital and office visits.

▪ Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the hospital's semi-private rate will not be covered unless a private room is ordered by your physician and precertification has been obtained.

▪ Charges made by a Skilled Nursing Facility for inpatient services and supplies. Daily room and board charges over the semiprivate rate will not be covered.

▪ Charges made for the administration of anesthetics.

▪ Charges for outpatient diagnostic laboratory and x-rays.

▪ Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing and storage of self-donated blood after the surgery has been scheduled.

Limitations:

Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.

-Specialized Care-

-Chemotherapy-

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.

-Radiation Therapy Benefits-

Covered expenses include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

-Outpatient Infusion Therapy Benefits-

Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a hospital; or
- A physician in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Limitations:

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Schedule*.

Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.

-Treatment of Infertility-

-Basic Infertility Expenses-

Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.

-Spinal Manipulation Treatment-

Covered expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the chart at the beginning of this *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your hospital stay; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating physician.

-Transplant Services-

Requires pre-certification. Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The network level of benefits is paid only for a treatment received at a facility designated by the plan's administrator for the type of transplant being performed. Each designated facility has been selected to perform only certain types of transplants. Services obtained from a facility that is not designated for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility for other types of services. Contact your plan's administrator for more information.

The plan covers:

- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent Not Covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; **or** upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each

phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;

2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and

4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an facility will be considered network care expenses.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is Not Covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise pre-certified.

-Network of Transplant Specialist Facilities-

Through the designated network, you will have access to a provider network that specializes in transplants. Benefits may vary if a facility or non-designated or out-of-network provider is used. In addition, some expenses are payable only within the designated network. The designated facility must be specifically approved and designated by the Plan to perform the procedure you require. Each facility in the designated network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

-Obesity Treatment-

Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam; and
- Prescription drugs.

-Morbid Obesity Surgical Expenses-

Covered medical expenses include charges made by a hospital or a physician for the surgical treatment of morbid obesity of a covered person provided the expenses are incurred at facility designated by your plan's administrator. **If the expenses are not incurred at a designated facility, no payment will be made under the plan.**

Coverage includes the following expenses as long as they are incurred within a two-year period:

- One morbid obesity surgical procedure including complications directly related to the surgery;
- Pre-surgical visits;
- Related outpatient services; and
- One follow-up visit.

This two-year period begins with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the related medical plan's covered medical expenses, subject to plan limitations and maximums.

Limitations:

Unless specified above, **Not Covered** under this benefit are charges incurred for:

- Morbid obesity surgical benefits for Bilio-Pancreatic Diversion surgical procedures.

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this *Schedule*; and

- Services which are covered to any extent under any other part of this Plan.

-Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)-

Covered expenses include charges made by a physician, a dentist and hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when **not** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a stay required because of your condition.

Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or

(b) Other body tissues of the mouth fractured or cut due to injury.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the injury.

The treatment must be completed in the calendar year of the accident or in the next calendar year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, covered expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth;

- The first crown needed to repair each damaged tooth; and

- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your health care provider. **The Plan covers only those services and supplies that are medically necessary and included in the *Covered Expenses* section.**

Charges made for the following are **Not Covered** except to the extent listed under the *Covered Expenses* section or by amendment attached to this *Schedule.*

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *Covered Expenses* section.

- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this *Schedule.*

- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain prescription drugs or supplies, even if otherwise covered under this *Schedule.* This also includes prescription drugs or supplies if:

  - such prescription drugs or supplies are unavailable or illegal in the United States; or

  - the purchase of such prescription drugs or supplies outside the United States is considered illegal.

- Behavioral health services, except as described elsewhere in this *Schedule of Benefits* as being covered. In particular, treatment of mental retardation, defects, and deficiencies are excluded, except as otherwise described in this *Schedule.* In addition, wilderness programs and similar programs intended for treatment of mental disorders, alcoholism or drug abuse treatment are excluded except to the extent they meet the Plan's accreditation standards and are supplying medically necessary treatment.

- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are Not Covered. For autologous blood donations, only administration and processing costs are covered.

- Charges for a service or supply furnished by a network provider in excess of the negotiated charge. Charges for a service or supply furnished by an out-of-network provider in excess of those that are "reasonable and customary" as determined in accordance with the terms of the Plan and the claims administrator's policies and standards.

- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

- Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

- Contraception, except as specifically described in the *Covered Expenses* Section:

  ▪ Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

- Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

  ▪ Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;

  ▪ Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;

  ▪ Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;

  ▪ Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when medically necessary;

  ▪ Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and

  ▪ Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;

  ▪ Surgery to correct Gynecomastia;

  ▪ Breast augmentation;

  ▪ Otoplasty.

- Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the *Covered Expenses* section.

- Court ordered services, including those required as a condition of parole or release.

- Custodial Care

- Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

  ▪ services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;

  ▪ dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and

  ▪ non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

- Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

- Drugs, medications and supplies:

  ▪ Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;

  ▪ Any services related to the dispensing, injection or application of a drug;

  ▪ Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;

  ▪ Immunizations related to work;

  ▪ Needles, syringes and other injectable aids, except as covered for diabetic supplies;

▪ Drugs related to the treatment of non-covered expenses;

▪ Performance enhancing steroids;

▪ Injectable drugs if an alternative oral drug is available;

▪ Outpatient prescription drugs;

▪ Self-injectable prescription drugs and medications;

▪ Any prescription drugs, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and

▪ Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

- Educational services:

▪ Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;

▪ Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, regardless of the underlying cause; and

▪ Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

- Examinations:

▪ Any health examinations required:

- by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- by any law of a government;

- for securing insurance, school admissions or professional or other licenses;
- to travel;
- to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and-Any special medical reports not directly related to treatment except when provided as part of a

covered service.

- Experimental or investigational drugs, devices, treatments or procedures, except as described in the *Covered Expenses* section.

- Facility charges for care services or supplies provided in:

  - nursing homes;

  - assisted living facilities;

  - similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;

  - health resorts;

  - spas;or

  - infirmaries at schools, colleges, or camps.

- Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

- Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

  - treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and

  - Shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

- Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

- Hearing:

  - Any hearing service or supply that does not meet professionally accepted standards;

- Hearing exams given during a stay in a hospital or other facility;

- Replacement parts or repairs for a hearing aid;

- Any service or supply furnished by out-of-network providers; and

- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided under the *Covered Expenses* section.

- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

  - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;

  - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;

  - Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;

  - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;

  - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;

  - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;

  - Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and

  - Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

- Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

- Infertility: except as specifically described in the *Covered Expenses* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception,

including but not limited to:

▪ Drugs related to the treatment of non-covered benefits;

▪ Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;

▪ Artificial Insemination;

▪ Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;

▪ Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;

▪ Procedures, services and supplies to reverse voluntary sterilization;

▪ Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;

▪ The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

▪ Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;

▪ Home ovulation prediction kits or home pregnancy tests;

▪ Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and

▪ Ovulation induction and intrauterine insemination services if you are not infertile.

- Maintenance Care

- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

- Miscellaneous charges for services or supplies including:

  ▪ Annual or other charges to be in a physician's practice;

  ▪ Charges to have preferred access to a physician's services such as boutique or concierge physician practices;

  ▪ Cancelled or missed appointment charges or charges to complete claim forms;

  ▪ Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:

  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;

  - Any care a public hospital or other facility is required to provide; or
  - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by the Plan, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

- Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

- Personal or professional growth services.

- Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the *Covered Expenses* Section.

- Professional certification or licensing diagnosis, treatment, or training.

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

- Services of a resident physician or intern rendered in that capacity.

- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

  ▪ Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and

  ▪ Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this *Schedule*.

- Services that are Not Covered under this *Schedule*.

- Services and supplies provided in connection with treatment or care that is Not Covered under the Plan.

- Speech therapy for treatment of delays in speech development, except as specifically provided in the *Covered Expenses Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

- Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *Covered Expenses* section.

- Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

  ▪ Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;

- Drugs or preparations to enhance strength, performance, or endurance; and

- Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are Not Covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This exclusion does not apply to speech therapy for the treatment of Autism or developmental delays.

- Therapies and tests: Any of the following treatments or procedures:

  - Aromatherapy;

  - Bio-feedback and bioenergetic therapy;

  - Carbon dioxide therapy;

  - Chelation therapy (except for heavy metal poisoning);

  - Computer-aided tomography (CAT) scanning of the entire body;

  - Educational therapy;

  - Gastric irrigation;

  - Hair analysis;

  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;

  - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;

  - Lovaas therapy;

  - Massage therapy;

  - Megavitamin therapy;

  - Primal therapy;

  - Psychodrama;

  - Purging;

  - Recreational therapy;

- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

- Tobacco Use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the *Covered Expenses* section.

- Transplant-The transplant coverage does not include charges for:

  - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  - Services and supplies furnished to a donor when recipient is not a covered person;
  - Home infusion therapy after the transplant occurrence;
  - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
  - Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;
  - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise pre-certified by the Plan.

- Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in the *Covered Expenses* section.

- Unauthorized services, including any service obtained by or on behalf of a covered person without pre-certification by the Plan when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

- Vision-related services and supplies, except as described in the *Covered Expenses* section. The plan does not cover:

  - Special supplies such as non-prescription sunglasses and subnormal vision aids;

- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

- Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; except as specifically provided in the *Covered Expenses* section, including but not limited to:

  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
  - Counseling, coaching, training, hypnosis or other forms of therapy; and
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

- Work related: Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are Not Covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Your Rights and Protections Against Surprise Medical Bills (No Surprises Act)

Effective January 1, 2022, the No Surprises Act may protect you from surprise medical bills under certain circumstances. Please see here for additional information.

Continuity of Care (Consolidated Appropriations Act)

Effective January 1, 2022, the Consolidated Appropriations Act allows certain patients the opportunity to continue care if their provider or facility is no longer in the Plan network. The Plan must permit members who are continuing care patients with an opportunity to request and election to continue to have benefits provided under the Plan under the same terms and conditions as they would have been covered had no change occurred. The timing starts on the date a notice of the right to elect continuing care is provided to the member and ends either 90 days later or the date on which the patient is no longer undergoing continuing care by that provider or facility.

Continuing care includes the following:

- Serious and complex conditions.
- Course of institutional or inpatient care.
- Scheduled nonelective surgery including post-operative care.
- Course of treatment for pregnancy.
- Terminally ill patients.