Schedule of Benefits

How Do You Access Benefits?

You can choose to receive Designated Network Benefits, Network Benefits or Out-of-Network Benefits.

Designated Network Benefits apply to Covered Health Care Services that are provided by a provider or facility that has been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Network Benefits.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Ground Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Plan Sponsor, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

The Claims Administrator requires prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call the Claims Administrator at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are

authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, Northwestern University urges you to confirm with the Claims Administrator that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, the Claims Administrator's final coverage determination will be changed to account for those differences, and the Plan will only pay and the Claims Administrator will only process payments for Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Payments made by the member will not accumulate to the DED/OOP.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Claims Administrator processes payments for Benefits under the Plan), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Claims Administrator will process payments for the Plan as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain prior authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term and Description Table

Payment Term And Description	Amounts	
	The Amount You Pay Designated Network and Network	**The Amount You Pay Out-of-Network**
Annual Deductible		
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *outpatient prescription drug plan*. The Annual Deductible for Network Benefits includes the amount you pay for both Network and Out-of-Network Benefits for outpatient prescription drugs provided under the *outpatient prescription drug plan.* Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	$4,000 per Covered Person, not to exceed $8,000 for all Covered Persons in a family.	$8,000 per Covered Person not to exceed $16,000 for all Covered Persons in a family.
Out-of-Pocket Limit		
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *outpatient prescription drug plan*. The Out-of-Pocket Limit for Network Benefits includes the amount you pay for both Network and Out-of-Network	$7,000 per Covered Person, not to exceed $14,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.	$14,000 per Covered Person, not to exceed $28,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts	
	The Amount You Pay Designated Network and Network	**The Amount You Pay Out-of-Network**
Benefits for outpatient prescription drug products provided under the *outpatient prescription drug plan.* Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.		
Copayment		
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount, or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		
Coinsurance		

Payment Term And Description	Amounts	
	The Amount You Pay Designated Network and Network	**The Amount You Pay Out-of-Network**
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		

Schedule of Benefits Table

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in *Section 9: Defined Terms*. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Ambulance Services			
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 20% *Air Ambulance:* 20%	Same as Network	Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 20% *Air Ambulance:* 20%	*Ground Ambulance:* Same as Network *Air Ambulance:* Same as Network	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes (Subject to Allowed Amount)*Air Ambulance:* Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes (Subject to Allowed Amount)*Air Ambulance:* Yes (Subject to Allowed Amount)	
Cellular and Gene Therapy			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Out-of-Network Benefits are not available.	For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.
Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*. Benefits are available when the Covered Health Care Services are provided by either Network or out-of-Network providers.
Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Dental Services - Accident Only			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Same as Network	PAY THE FOLLOWING DENTAL PROCEDURES WHEREVER RENDERED A) EXCISION OF TUMORS AND CYSTS OF THE JAWS,CHEEKS,LIPS, TONGUE,ROOF AND FLOOR OF THE MOUTH B) SURGICAL PROCEDURES REQUIRED TO CORRECT
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	ACCIDENTAL INJURIES OF JAWS,CHEEKS,LIPS,TONGUE,ROOF AND FLOOR OF THE MOUTH WHEN SUCH INJURIES OCCUR ON/AFTER THE COVERAGE DATE C) EXCISION OF EXOTOSES OF THE JAWS AND HARD PALATE PROVIDED SUCH PROCEDURE IS NOT DONE IN PREPARATION FOR A PROSTHESIS D) TREATMENT OF FRACTURES OF FACIAL BONES E)EXTERNAL INCISION AND DRAINAGE OF CELLULITIS OR INCISION OF ACESSORY SINUSES,SALIVARY GLANDS/DUCTS F)REDUCTION OF, DISLOCATION OF, OR EXCISION OF THE TEMPOROMANDIBULAR JOINTS Based on this statement, the member must have been covered at the time of the accident and the service must be rendered while the patient is a covered member. There is no indication of a time limit after the accident occurred.
Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. For diabetes supplies, you pay 20% of the Allowed Amount and the Annual Deductible applies. Coinsurance applies to the Out-of-Pocket Limit.	For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. For diabetes supplies, you pay 40% of the Allowed Amount and the Annual Deductible applies. Coinsurance applies to the Out-of-Pocket Limit.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	To receive Network Benefits, you must obtain the DME or orthotic from the vendor the Claims Administrator identifies or from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Emergency Health Care Services - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Same as Network	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Enteral Nutrition			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Fertility Preservation for Iatrogenic Infertility			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.** **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Habilitative Services			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Hearing Aids			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	Limited to one hearing aid per hearing impaired ear every 24 months. Benefits for members age 18 and over are further limited to $2500 per hearing aid.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies. ***NOTE:*** Private duty nursing is described under *Private Duty Nursing*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Hospital - Inpatient Stay			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Infertility Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	Benefits for Oocyte retrieval is limited to four completed cycles per calendar year. If a live birth followed a complete oocyte retrieval, Health Services will include two additional oocyte retrievals.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, for Genetic Testing, and sleep studies, you must obtain prior authorization five business days before scheduled services are received.			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Major Diagnostic and Imaging - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Program(s); Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*; psychological testing and transcranial magnetic stimulation.			
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Office Visits* 20% *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 20% *Intensive Behavioral Therapy* 20%	*Office Visits* 40% *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 40% *Intensive Behavioral Therapy* 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	*Office Visits* Yes (Subject to Allowed Amount)*All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes (Subject to Allowed Amount)*Intensive Behavioral Therapy* Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	*Office Visits* Yes (Subject to Allowed Amount)*All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes (Subject to Allowed Amount)*Intensive Behavioral Therapy* Yes (Subject to Allowed Amount)	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** AbleTo None	Out-of-Network Benefits are not available.	Except for the initial consultation, Covered Persons with a high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, Copayments or Coinsurance for the initial consultation.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	Yes, only for treatments after the initial consultation.	Out-of-Network Benefits are not available.	
Non-Preventive Nutritional Counseling			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* Benefits for non-preventive nutritional counseling services for mental health and substance-related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* Benefits for non-preventive nutritional counseling services for mental health and substance-related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.	
Obesity - Weight Loss Surgery			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of obesity - weight loss surgery arises. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Ostomy Supplies			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Pharmaceutical Products - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	Pharmacy Benefits handled through CVS.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Physician Fees for Surgical and Medical Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Allowed Amounts will be determined as described below under
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	*Allowed Amounts* in this *Schedule of Benefits*.
Physician's Office Services - Sickness and Injury			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. **It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preimplantation Genetic Testing (PGT) and Related Services			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	Benefits for Assisted Reproductive Technology (ART) for related services as described under *Infertility Services* do not include the Preimplantation genetic testing for the specific genetic disorder.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Preventive Care Services			
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	N/A	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	No	Yes (Subject to Allowed Amount)	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	40%	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	No	Yes (Subject to Allowed Amount)	
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	No	Yes (Subject to Allowed Amount)	
Private Duty Nursing			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Prosthetic Devices			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, for sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Temporomandibular Joint (TMJ) Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, intensity modulated radiation therapy, and MR-guided focused ultrasound.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Urgent Care Center Services			

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Urinary Catheters			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes (Subject to Allowed Amount)	
Does the Annual Deductible Apply?	Yes	Yes (Subject to Allowed Amount)	
Virtual Care Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Out-of-Network Benefits are not available.	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	

Covered Health Care Service	The Amount You Pay Designated Network and Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Out-of-Network Benefits are not available.	

Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying the Claims Administrator.

Please note that in listing services or examples, when the Plan says "this includes," it is not the Claims Administrator's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Plan states specifically that the list "is limited to."

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as the Claims Administrator determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services.*

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.

- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.

    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of Fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for CHD services.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for blood glucose meters, including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices may be available through the *outpatient prescription drug plan*. Pharmacy Benefits handled through CVS Caremark.

Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.

- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *SPD*.
- Shoe inserts, arch supports and shoe orthotics when prescribed by a Physician.
- Shoes (standard or custom), lifts and wedges.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Benefits also include dedicated speech-generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

The Claims Administrator will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits are available for services to treat a condition that does not meet the definition of an Emergency.

Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

Examination and Treatment for Sexual Assault

Full coverage, with no member cost share In and Out of Network, for the examination and testing of the victim of a criminal sexual assault or abuse to establish that sexual contact did or did not occur, to establish the presence or absence of sexually transmitted disease or infection, and to treat the injuries and trauma sustained by the victim of the offense.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.

- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*.

In addition to standard coverage, there is coverage for services, procedures, or surgical treatments relating to gender-affirming care including plastic or cosmetic surgery. Coverage includes:

- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal in addition to when part of a genital reconstruction procedure by a physician.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a medical or behavioral disabling condition to learn or improve skills and functioning for daily living. The Claims Administrator will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical

management. Therapies provided for the purpose of general well-being or conditioning in the absence of a medical or behavioral disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a medical or behavioral disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Educational/vocational training.
- Residential Treatment.
- A service or treatment plan that does not help you meet functional goals.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

The Claims Administrator may require the following be provided:

- Medical records.
- Other necessary data to allow the Claims Administrator to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress the Claims Administrator may request additional medical records.

- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices*.

Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *SPD*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's guidelines for hospice care.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Infertility Services

Services for the treatment of infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

To be eligible for Benefits, you must meet all of the following:

- You are not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
  - One year, if you are a female under age 35.
  - Six months, if you are a female age 35 or older.
- You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

For the purpose of this Benefit, "therapeutic donor insemination" means insemination with a donor sperm sample to enable a female to become pregnant.

Infertility Service Health Services for the diagnosis and treatment of infertility when provided by or under the direction of a Network Physician.

Infertility means (a)The inability to conceive after one year of unprotected sexual intercourse, (b) the inability to conceive after one year of attempts to produce conception, (c)the inability to conceive after an individual is diagnosed with a condition affecting fertility, or (d) the inability to sustain a successful pregnancy.

Coverage is subject to the following conditions: The Covered Person must be unable to sustain a successful pregnancy through other less costly infertility treatments covered under this policy.

The Covered Person must not have undergone four completed oocyte retrievals in a year. If a live birth followed a complete oocyte retrieval, Health Services will include two additional oocyte retrievals.

The infertility procedures must be performed at facilities conforming to either The American College of Obstetric and Gynecology guidelines or The American Fertility Society minimum standards.

Covered procedures include but are not limited to the following: - In vitro fertilization.- Uterine embryo lavage.- Embryo transfer.- Artificial insemination.- Zygote intrafallopian tube transfer.- Gamete intrafallopian tube transfer.- Low tubal ovum transfer.

Coverage is included for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm.

Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings, and prescription drugs.

Fertility treatments are not available for dependents under the age of 18.

Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Mental Health Care and Substance-Related and Addictive Disorders Services

The Mental Health/Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Mental Health and Substance-Related and Addictive Disorders Services. If you need

assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Care Services, you can contact the telephone number on your ID card.

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Programs.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis* (*ABA*)) that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a *Board Certified Behavior Analyst* (*BCBA*) or other qualified provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

  This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *SPD*.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Naprapathy

Naprapathy is a system or method of treating disease that employs no medications but uses manipulation of muscles, joints, ligaments, etc., to stimulate the natural healing process, when performed by a licensed Naprapath. Limited to 25 visits per calendar year, combined between In and Out of Network. Covered at In and Out of Network plan level deductible and coinsurance.

Non-Preventive Nutritional Counseling

Non-preventive nutritional counseling services for mental health and substance-related and addictive disorders and medical diagnosis that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity - Weight Loss Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- You have a body mass index (BMI) of greater than 40.
- You have a body mass index (BMI) of greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *SPD*.

If you require certain Pharmaceutical Products the Claims Administrator may direct you to a Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, Specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is

subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parent's chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.

- Embryo transfer.
- Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).
  - Timing of purchase or rental.

Pump Type	Coverage Levels	Qualifying Source	Limits/Restrictions
Manual Breast Pump	• 100% billed charges • No cost-share	• In-Network • Out of Network • Retail Providers	Retail providers (*example*: Target, Walmart, and so on) or online vendors: the member is responsible for sales tax, which is excluded from coverage.
Electric Breast Pump	• 100% • No cost-share	In-network provider or contracted DME supplier only*	• Effective January 1, 2018, or upon renewal dates, only one pump per benefit period is allowed.

Hospital Grade Breast Pump	• 100% • No cost-share Rental **Only** • See limit/restriction	In-network or contracted DME supplier*	• Hospital grade pump only available for monthly DME rental. • Coverage is up to the purchase price of $1,000 or 12 months whichever comes first. Upon end of coverage, unit must be returned to DME provider.

Private Duty Nursing – Outpatient

Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. Psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- Vision therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles.

Diagnosis: Exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.

- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Plan, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for transplant services.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Urinary Catheters

Benefits are provided for external, indwelling, and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

- Benefits are available for urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency needs.

Please Note: Not all conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Exclusions and Limitations

How Are Headings Used in this Section?

To help you find exclusions, this section contains headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Does Not Pay Benefits for Exclusions

The Plan will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through an SMM or Amendment to the Plan.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when the exclusion or limitation says that "this includes," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the exclusion or limitation will state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities (stair safety gates, special shoes/training equipment for sporting activities, etc.).
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
4. Devices and computers to help in communication and speech except for dedicated speech-generating devices and tracheo-esophageal voice devices for which Benefits are provided as

described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Over-the-counter continuous glucose monitors.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another Pharmaceutical

Product, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.

11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

Foot Care

1. Routine foot care. Examples include:
   - Cutting or removal of corns and calluses.
   - Nail trimming, nail cutting, or nail debridement.
   - Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic or peripheral vascular disease.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and certain disposable supplies.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under Diabetes Services in *Section 1: Covered Health Care Services*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services*.
   - Urinary catheters and related urologic supplies for which Benefits are provided as described under Urinary Catheters in *Section 1: Covered Health Care Services*.
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.

4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Nutrition

1. Non-preventive nutritional counseling that is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* or to Benefits provided under *Non-Preventive Nutritional Counseling* as described in *Section 1: Covered Health Care Services*.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services.*
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot and cold compresses.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.

- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
    - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
    - Treatment for spider veins.
    - Sclerotherapy treatment of veins.
    - Permanent hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a medical or behavioral disabling condition.
6. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
7. Biofeedback.
8. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
9. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.
10. Non-surgical treatment of obesity other than physician office visits related to the prescribing of GLP-1s if covered as part of the pharmacy benefit.
11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*. This exclusion does not apply to breast reduction surgery for treatment of gender dysphoria.
13. Helicobacter pylori (H. pylori) serologic testing.
14. Intracellular micronutrient testing.
15. Cellular and Gene Therapy services not received from a Designated Provider.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. The following Infertility treatment-related services:
    - Cryo-preservation and other forms of preservation of reproductive materials except as described under *Infertility Services*. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Section 1: Covered Health Care Services*.
    - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
    - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
    - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
    - Ovulation predictor kits.
2. The following services related to a Gestational Carrier or Surrogate:
    - Fees for the use of a Gestational Carrier or Surrogate.
    - Insemination costs of or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
    - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.
4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
    - Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
    - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
    - Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
    - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
5. The reversal of voluntary sterilization.
6. InVitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility. This exclusion does not apply to InVitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services* in *Section 1: Covered Health Care Services*.
7. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
8. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
9. Infertility treatment following unsuccessful reversal of voluntary sterilization.

10. Infertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).
11. Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.
12. Elective fertility preservation.

Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health care services for transplants involving animal organs.

Travel

1. Travel or transportation expenses, even though prescribed by a Physician, except as identified under *Complex Medical Conditions Travel and Lodging Assistance Program* in *Clinical Programs and Resources*. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back at the Claims Administrator's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

Types of Care, Supportive Services, and Housing

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing Inpatient.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.

6. Rest cures.
7. Services of personal care aides.
8. Independent living services.
9. Assisted living services.
10. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individual with Disabilities Education Act*.
11. Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
12. Transitional Living services (including recovery residences).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction. Exclusion does not apply for pediatric vision exams as required under the Affordable Care Act.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
5. Bone anchored hearing aids except when either of the following applies:
    - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
    - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

    More than one bone anchored hearing aid per ear per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Plan.

    Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.
6. Over-the-counter hearing aids.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
    - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
    - Medically Necessary.
    - Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:

- Required only for school, sports or camp, career or employment, insurance, marriage or adoption.
- Related to judicial or administrative proceedings or orders unless Medically Necessary.
- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
- Required to get or maintain a license of any type.

3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.
6. Health care services when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected by an out-of-Network provider.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Claims Administrator would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.