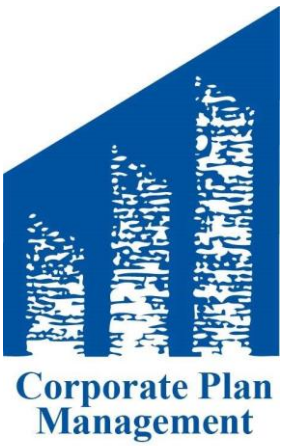

Complete Employee Benefit Solutions

SOUTHWEST KANSAS CHAMBER ALLIANCE
HEALTH PROTECTION PLAN

Summary Plan Description
Effective: 1/1/2020

SUMMARY OF BENEFITS

14.01 General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out-of-pocket Deductible has been satisfied. Benefits for Pregnancy expenses are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. **"Utilization Management"** includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled "Cost Containment."

The Plan contracts with the medical provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. **The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used.**
2. **If the charge billed by a Non-Network Provider for any covered service is higher than the Usual, Customary and Reasonable Fees determined by the Plan, Participants are responsible for the excess. Since Network Providers have agreed to accept the negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.**
3. **To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.**

Primary Care Providers

Providers located within the state of Kansas: A current list of providers is available, without charge, through the website located at *www.ProviDRsCare.net*

Providers located outside the state of Kansas: A current list of providers is available, without charge, through the website located at *www.FirstHealth.com*

Each Participant has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Participant, together with his or her physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

14.02 Plan Year Maximum Benefit

The following plan year maximums apply to each Participant:

Plan Year Maximum Benefits for:	
All Essential Health Benefits	Unlimited

NOTE: Medical Copays are not applicable in Plan D and E. All charges are subject to deductible, with the exception of preventive care services. Once the deductible has been met all covered services and prescriptions are paid at 100%.

14.03 Summary of Medical Benefits

The following benefits are per Participant per calendar year:

	Network	Non-Network
Deductible • Individual • Family Unit	Plan A / Plan B / Plan C / Plan D / Plan E $1,000 / $2,500 / $5,500 / $4,000 / $7,900 $2,000 / $5,000 / $11,000 / $8,000 / $15,800	Plan A / Plan B / Plan C / Plan D / Plan E $2,000 / $3,500 / $7,900 / $8,000 / $15,800 $4,000 / $7,000 / $15,800 /$16,000 /$31,600
Co-Insurance Level (Participant)	20% / 20% / 20% / 0% / N/A	40% / 40% / 40% / 0% / N/A
Maximum Out-of-Pocket[1]		
• Individual • Family Unit	Plan A / Plan B / Plan C / Plan D / Plan E $2,000 / $3,500 / $7,900 / $4,000 / $7,900 $4,000 / $7,000 / $15,800 / $8,000 / $15,800	Plan A / Plan B / Plan C / Plan D / Plan E $4,000 / $7,000 / $15,800 / $8,000 / $15,800 $8,000/$14,000/$31,600/$16,000 / $31,600

Covered Medical Expenses:	Network	Non-Network	Max. Ins. Pays[2]
1. Allergy Services • Office Visit • Injections • Serum	 $25 co-pay 100% Ded./co-ins.	 Ded./co-ins. Ded./co-ins. Ded./co-ins.	 No Max
2. Ambulance	Ded./co-ins.	Ded./co-ins.	No Max
3. Ambulatory Surgical Center	Ded./co-ins.	Ded./co-ins.	No Max
4. Anesthesia	Ded./co-ins.	Ded./co-ins.	No Max
5. Birthing Center	Ded./co-ins.	Ded./co-ins.	No Max
6. Blood & Plasma	Ded./co-ins.	Ded./co-ins.	No Max
7. Breast Pump	100%	100%	1 per year
8. Chiropractic Care	$25 co-pay	Ded./co-ins.	20 visits per year
9. Durable Medical Equipment	Ded./co-ins.	Ded./co-ins.	No Max
10. Emergency Room Visit	Ded./co-ins.	Ded./co-ins.	No Max
11. Glaucoma, Cataract Surgery and Lenses (one set)	Ded./co-ins.	Ded./co-ins.	No Max
12. Home Health Care	Ded./co-ins.	Ded./co-ins.	60 visits per year
13. Hospice Care • Inpatient/Outpatient	 Ded./co-ins.	 Ded./co-ins.	Inpatient 30 days Outpatient 60 visits
14. Hospital • Inpatient & Outpatient Treatment	 Ded./co-ins.	 Ded./co-ins.	
15. Newborn Care	Ded./co-ins.	Ded./co-ins.	No Max
16. Out-of-Network Benefit	N/A	100%	$500 Annual Max.
17. Outpatient Diagnostic X-ray and Lab	Ded./co-ins.	Ded./co-ins.	No Max
18. Outpatient Services	Ded./co-ins.	Ded./co-ins.	No Max
19. Physician Office Visit	$25 co-pay	Ded./co-ins.	No Max
20. Pre-Admission Testing	100%	100%	No Max

[1] Includes deductibles and coinsurance. Excludes co-payments and amounts over Usual, Customary and Reasonable Fees.

[2] These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

Covered Medical Expenses:	Network	Non-Network	Max. Ins. Pays[2]
21. Pregnancy Expenses	Ded./co-ins.	Ded./co-ins.	No Max
22. Private Duty Nursing	Ded./co-ins.	Ded./co-ins.	$2,500 Annual Max.
23. Prosthetics, Orthotics, Supplies and Surgical Dressings	Ded./co-ins.	Ded./co-ins.	No Max
24. Scans – CT and MRI	Ded./co-ins.	Ded./co-ins.	No Max
25. Second Surgical Opinions 26. Third Surgical Opinions	100% 100%	Ded./co-ins. Ded./co-ins.	No Max
27. Skilled Nursing Facility	Ded./co-ins.	Ded./co-ins.	60 Days Per Year
28. Specialist Office Visit	$25 co-pay	Ded./co-ins.	No Max
29. Surgery	Ded./co-ins.	Ded./co-ins.	No Max
30. Surgical Consultation	$25 co-pay	Ded./co-ins.	No Max
31. Temporomandibular Joint Disorder (TMJ)	Ded./co-ins.	Ded./co-ins.	$2,500 Lifetime Max.
32. Therapy			No Max
• Chemotherapy/Radiation Therapy	Ded./co-ins.	Ded./co-ins.	
• Occupational Therapy - Inpatient	Ded./co-ins.	Ded./co-ins.	
• Occupational Therapy - Outpatient	$25 co-pay	Ded./co-ins.	
• Physical Therapy - Inpatient	Ded./co-ins.	Ded./co-ins.	
• Physical Therapy - Outpatient	$25 co-pay	Ded./co-ins.	
• Respiration Therapy - Inpatient	Ded./co-ins.	Ded./co-ins.	
• Respiration Therapy - Outpatient	$25 co-pay	Ded./co-ins.	
• Speech Therapy – Inpatient	Ded./co-ins.	Ded./co-ins.	
• Speech Therapy - Outpatient	$25 co-pay	Ded./co-ins.	
33. Transplants	Ded./co-ins.	Ded./co-ins.	No Max
34. Urgent Care Services	$25 co-pay	Ded./co-ins.	No Max
35. Vision Exam and Refractions	100%	100%	1 Exam Per Year
36. All Other Covered Services	Ded./co-ins.	Ded./co-ins.	No Max

14.04 Summary of Preventive Care Benefits

The following benefits are per Participant, per calendar year:

	Network	Non-network	
1. Preventive Care			
• Routine Physical Exam	100%	Ded./co-ins.	
• Mammograms/Pap Smears	100%	Ded./co-ins.	
• Colonoscopy	100%	Ded./co-ins.	
• Prostate Exam	100%	Ded./co-ins.	
• Routine Immunizations	100%	100%	Covered for all children, adolescents and adults when the immunizations have in effect a recommendation from the advisory commits on Immunization practices of the Centers for Disease Control and Prevention with respect to the child, adolescent, or adult involved
• Asprin to prevent Cardio Vascular Disease	100%	Ded./co-ins.	Covered for men ages 45-79 and women ages 55-79
• Breastfeeding support, supplies and counseling	100%	Ded./co-ins.	Covered in conjunction with a birth
• Chemoprevention of breast cancer	100%	Ded./co-ins.	Covered for women at high risk for breast cancer

• Contraceptives	100%	100%	All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity
• Counseling and screening for interpersonal and domestic violence	100%	Ded./co-ins.	Provided annually for all women
• Counseling for a healthy diet	100%	Ded./co-ins.	Covered for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease
• Counseling for sexually transmitted infections	100%	Ded./co-ins.	Covered for all sexually active adolescents and adults
• Counseling for tobacco use	100%	Ded./co-ins.	Covered for all adults who use tobacco
• Counseling related to breast cancer screenings	100%	Ded./co-ins.	Covered for women with a family history for breast cancer, and related mutations
• Evidence-informed preventive care and screenings	100%	Ded./co-ins.	Covered for infants, children, adolescents and women when provided for in the comprehensive guidelines supported by the Health resources and Service Administration
• Interventions to support breast feeding	100%	Ded./co-ins.	Covered during and after pregnancy
• Iron supplementation in children	100%	Ded./co-ins.	Covered for children aged 6-12 months or are at increased risk for an iron deficiency
• Prophylactic medication for gonorrhea	100%	Ded./co-ins.	Ocular topical medication is covered for all newborns
• Screening and counseling for obesity	100%	Ded./co-ins.	Covered for adult patients and children age 6 and older who are at risk for obesity
• Screening and counseling to reduce alcohol misuse	100%	Ded./co-ins.	Covered for adults, including pregnant women
• Screening for abdominal aortic aneurysm	100%	Ded./co-ins.	Covered for men age 65 to 75 who have ever smoked
• Screening for bacteriuria	100%	Ded./co-ins.	Covered for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later
• Screening for breast cancer (mammography)	100%	Ded./co-ins.	Covered for women age 40 or older, one annually
• Screening for cholesterol abnormalities	100%	Ded./co-ins.	Covered for men age 20 and older who are at an increased risk for coronary heart disease, women age 20 or older when they are at an increased risk for coronary heart disease
• Screening for colorectal cancer	100%	Ded./co-ins.	Covered for persons age 50 to 75
• Screening for congenital hypothryodism	100%	Ded./co-ins.	Covered for all newborns
• Screening for depression	100%	Ded./co-ins.	Covered for adults and adolescents age 12-18
• Screening for diabetes	100%	Ded./co-ins.	Covered in asymptomatic adults with sustained blood pressure greater than 135/80 mm Hg

• Screening for gestational diabetes	100%	Ded./co-ins.	Covered for all pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes
• Screening for gonorrhea	100%	Ded./co-ins.	Covered for all sexually active women, including those who are pregnant
• Screening for hearing test	100%	Ded./co-ins.	Covered for all participants
• Screening for hemoglobinopathies	100%	Ded./co-ins.	Screening for sickle cell disease in all newborns
• Screening for hepatitis	100%	Ded./co-ins.	Covered for all pregnant women
• Screening for high blood pressure	100%	Ded./co-ins.	Covered for adults age 18 and older
• Screening for HIV	100%	Ded./co-ins.	Covered for all adolescents and adults at risk for HIV
• Screening for human papillomavirus	100%	Ded./co-ins.	Covered for all women beginning at 30 years of age and should occur no more frequently than every three years
• Screening for iron deficiency anemia	100%	Ded./co-ins.	Covered for pregnant women
• Screening for osteoporosis	100%	Ded./co-ins.	Women age 65 and older, or age 60 and older for women with an increased risk for osteoporotic fractures
• Screening for PKU	100%	Ded./co-ins.	Covered for newborns
• Screening for Rh incompatibility	100%	Ded./co-ins.	Covered for pregnant women
• Screening for Rh incompatibility	100%	Ded./co-ins.	Covered for all pregnant women at 24-28 weeks of gestation
• Screening for syphilis	100%	Ded./co-ins.	Covered for all persons at increased risk for syphilis
• Screening for syphilis	100%	Ded./co-ins.	Covered for all pregnant women
• Screening for visual acuity in children	100%	Ded./co-ins.	Covered for children up to age 5
• Screenings for cervical cancer	100%	Ded./co-ins.	Covered for all women who have been sexually active or have a cervix
• Screenings for chlamydial infections	100%	Ded./co-ins.	Covered for all sexually active, non-pregnant women age 24 and younger and for older non-pregnant women who are at increased risk for chlamydial infections
• Supplementation with folic acid	100%	Ded./co-ins.	Covered for pregnant women
• Well-woman visits	100%	Ded./co-ins.	Covered for all women

Note that this list will be updated from time to time and a current list of covered preventive care services is available at all times by visiting www.HealthCare.gov/center/regulations/prevention.html

14.05 Summary of Psychiatric Benefits
The following benefits are per Participant, per calendar year:

Covered Psychiatric Expenses:	Network	Non-Network	Limits
1. Residential Treatment	Ded./co-ins.	Ded./co-ins.	60 Days Per Year
2. Inpatient Physician	Ded./co-ins.	Ded./co-ins.	
3. Partial Day Program	Ded./co-ins.	Ded./co-ins.	
4. Outpatient Physician	$25 co-pay	Ded./co-ins.	

14.06 Summary of Substance Abuse Benefits
The following benefits are per Participant, per calendar year:

Covered Substance Abuse Expenses:	Network	Non-Network	Limits
1. Residential Treatment	Ded./co-ins.	Ded./co-ins.	60 Days Per Year
2. Inpatient Physician	Ded./co-ins.	Ded./co-ins.	
3. Partial Day Program	Ded./co-ins.	Ded./co-ins.	
4. Outpatient Physician	$25 co-pay	Ded./co-ins.	

14.07 Summary of Prescription Drug Benefits
The following benefits are per Participant:

Covered Prescription Drug Expenses:	Participating Pharmacy	Limits
Pharmacy Option – Plan 1:		
Copayment, per prescription or refill, for generic	$1	See Article XVI
Copayment, per prescription or refill, for preferred name brands	$75	See Article XVI
Copayment, per prescription or refill, for non-preferred name brands	$150	See Article XVI
Copayment, per prescription or refill, for specialty	$250	See Article XVI

Covered Prescription Drug Expenses:	Participating Pharmacy	Limits
Pharmacy Option - Plan 2:		
Copayment, per prescription or refill, for generic	$1	See Article XVI
Copayment, per prescription or refill, for preferred name brands	50% co-ins.	See Article XVI
Copayment, per prescription or refill, for non-preferred name brands	50% co-ins.	See Article XVI
Copayment, per prescription or refill, for specialty	50% co-ins.	See Article XVI

Covered Prescription Drug Expenses:	Participating Pharmacy	Limits
Pharmacy Option - Plan 3:		
Copayment, per prescription or refill, for generic	$1	See Article XVI
Copayment, per prescription or refill, for preferred name brands	$75	See Article XVI
Copayment, per prescription or refill, for non-preferred name brands	$150	See Article XVI
Copayment, per prescription or refill, for specialty	N/A	Excluded

NOTE: Prescription Copays are not applicable in Plan D. All Medical charges are subject to deductible, with the exception of preventive care services. Once the deductible has been met all covered services and prescriptions are paid at 100%. NOTE: 90-day Maintenance prescriptions will have a copay of 2.5 times the copays stated above.

ARTICLE XV
MEDICAL BENEFITS

15.01 Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Allergy Services.** Charges related to the Treatment of allergies;
2. **Ambulance.** Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition;
3. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;
4. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;
5. **Autism Spectrum Disorder.** Charges for diagnosis and treatment of autism spectrum disorder for children less than 12 years of age;
6. **Birthing Center**. Services of a Birthing Center for Medically Necessary care provided within the scope of its license;
7. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;
8. **Breast Pumps.** One breast pump per year, manual or electric, will be covered at 100%;
9. **Chemotherapy.** Charges for chemotherapy/radiation;
10. **Chiropractic Care.** Office visit, **s**pinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Schedule of Benefits;
11. **Dental.** Dental Services, Oral Surgery And Other Related Services: The Plan will pay for the following limited dental services: Administration of general anesthetic and Facility charges determined by the Plan to be Medically Necessary for dental care, and provided to the following persons: Dependent children seven (7) years of age or under; a dependent who is severely disabled; or a participant who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided. Benefits for oral surgical procedures of the jaw or gums will be covered for: Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; Removal of symptomatic exostoses (bony growths) of the jaw and hard or soft palate; Treatment of fractures and dislocations of the jaw and facial bones; Laceration of mouth, tongue or gums; Intraoral x-rays in connection with covered oral surgery; General anesthetic for covered oral surgery; and Biopsies and associated lab work in connection with covered oral surgery. **Note: Emergency dental claims will not be covered by the Medical Plan;**
12. **Diabetic Education.** Charges will be subject to the same payment provisions as an office visit;
13. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;
14. **Durable Medical Equipment.** Charges for purchase of Durable Medical Equipment (including repair and replacement) every three years, including glucose home monitors for insulin-Dependent diabetics. At its option, the Plan may cover the rental of such items when it is less costly and more practical than purchase.
    If the equipment is purchased, benefits will be payable for subsequent repairs necessary to restore the equipment to a serviceable condition up to the maximums in the Schedule of Benefits. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered;
15. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);
16. **Glaucoma.** Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);
17. **Gleevec.** Gleevec, for treatment of any of the following conditions:
    a. CML myeloid blast crisis;
    b. CML accelerated phase; or
    c. CML in chronic phase after failure of interferon treatment;
    Prior authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan;
18. **Home Health Care.** Charges by a Home Health Care Agency:
    a. Registered Nurses or Licensed Practical Nurses;

b. Certified home health aides under the direct supervision of a Registered Nurse;
c. Registered therapist performing physical, occupational or Speech Therapy;
d. Physician calls in the office, home, clinic or Outpatient department;
e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Covered Person that would have been provided in the Hospital, but not including Custodial Care; and
f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

Please Note: Transportation services are not covered under this benefit;

19. **Hospice Care.** Charges relating to Hospice Care, provided the Covered Person has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Schedule of Benefits. Covered Hospice expenses are limited to:
    a. Room and Board for Confinement in a Hospice;
    b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
    c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
    d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
    e. Home health aide services;
    f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
    g. Medical social services by licensed or trained social workers, Psychologists or counselors;
    h. Nutrition services provided by a licensed dietitian;
    i. Respite care; and
    j. Bereavement counseling, which is a supportive service provided by the Hospice team to Covered Persons in the deceased's Family after the death of the Terminally Ill person, to assist the Covered Persons in adjusting to the death. Benefits will be payable up to 15 visits per Family if the following requirements are met:
        (1) On the date immediately before his or her death, the Terminally Ill person was in a Hospice Care Program and a Covered Person under the Plan; and
        (2) Charges for such services are Incurred by the Covered Persons within 6 months of the Terminally Ill person's death.

    The Hospice Care Program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission;
20. **Hospital.** Charges made by a Hospital for:
    a. Inpatient Treatment
        (1) Daily Semi-Private Room and Board charges;
        (2) Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
        (3) General nursing services; and
        (4) Medically Necessary services and supplies furnished by the Hospital, other than Room and Board

    ***Pre-admission certification required for all planned inpatient admissions at 1-800-859-8330.**
    b. Outpatient Treatment
    c. Emergency room.
21. **Immunizations.** Charges for immunizations per CDC guidelines will be paid at 100%. All other immunizations will apply to ded./co-ins. Immunizations for travel outside the U.S. suggested by CDC guidelines will not be covered by the Plan;
22. **Mastectomy**. The federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

    As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:
    a. Reconstruction of the breast on which the Mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. Prostheses and physical complications from all stages of Mastectomy, including lymphedamas;

in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

23. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics;
24. **Newborn Care.** Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the child's coverage, and the child's own Deductible and coinsurance provisions will apply;
    a. Hospital routine care for a Newborn during the child's initial Hospital Confinement at birth; and
    b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
        (1) The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
        (2) Circumcision.

    NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;
25. **Nicotine Cessation.** Services related to treatment by a physician for nicotine cessation. The benefit will be paid at 100% up to $1200 lifetime maximum benefit for in-network providers and out-of-network providers;
26. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;
27. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility;
28. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths;
29. **Osseous Surgery.** Charges for osseous Surgery;
30. **Out-of-Network Benefit.** Treatment or services rendered at an out-of-network facility or by an out-of-network provider. The benefit will be paid at 100% up to $500 annual maximum benefit and then applies to deductible and/or co-insurance;
31. **Outpatient Diagnostic Laboratory and Radiology Services.** Charges for lab and radiology services provided on an outpatient basis;
32. **Pathology Services.** Charges for Pathology Services;
33. **Physical Therapy.** Treatment or services rendered by a State licensed physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility;
34. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, consultations, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations;
35. **Pregnancy Services**. "Pregnancy" shall mean childbirth and conditions associated with Pregnancy, including complications. Pregnancy for covered Employees and covered spouses will be covered benefits, however, Pregnancy of a Dependent Child is limited to only the expenses of the mother, not the newborn child.

    Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

    Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the "Schedule of Benefits" and this section, and subject to the same maximums;

36. P**rescription Contraceptives.** The Plan will cover prescription contraceptives at 100% for all women with reproductive capacity. The Plan will also cover contraception-related services, including the initial visit to the prescribing Physician and any follow-up visits or Outpatient services, to the same extent, and on the same terms, as it offers coverage for other Outpatient services for preventative care;
37. **Preventive Care.** Charges for preventive care services as described in the Schedule of Benefits;
38. **Private Duty Nursing.** Private duty nursing (outpatient only). Maximum annual benefit is $2,500;
39. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes;
40. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;
41. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;
42. **Routine Eye Exam.** Charges for a routine eye exam and refractions. One exam per year;
43. **Second and Third Surgical Opinions.** Charges for second and third surgical opinions;
44. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Schedule of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Covered Person is confined. 60 visits per plan year benefit;
45. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;
46. **Sterilization**. Charges related to sterilization procedures;
47. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
    a. Multiple procedures adding significant time or complexity will be allowed at:
       100% of the full Usual, Customary and Reasonable Fee value for the first or major procedure;
    b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual, Customary and Reasonable Fee value for the major procedure, and 40% of the Usual, Customary and Reasonable Fee value for the secondary or lesser procedure;
    c. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;
    d. Benefits for an assistant surgeon will be paid at 50% of the primary surgeon's fee;
48. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist; and
49. **Temporomandibular Joint Dysfunction (TMJ)**. Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment. Maximum lifetime benefit is $2,500. **If a Physician or Dentist recommends treatment for or in connection with temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment, a Participant must submit the treatment plan, including x-rays and study models, for pre-determination of benefits under the Plan. The pre-determination of benefits is required before any course of treatment is begun**. The Plan Administrator will determine if the treatment is a Covered Expense and will notify the Participant. If treatment is begun before the pre-determination of benefits, no benefits are payable under the Plan; and
50. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:
    a. Bone marrow;
    b. Heart;
    c. Lung;
    d. Heart and lung;
    e. Liver;
    f. Pancreas;
    g. Kidney; and

h. Cornea.

In addition, the Plan will cover any other transplant that is not Experimental.

Covered expenses will be paid at 100% following the deductible at designated pre-authorized transplant facilities; expenses at non-designated transplant facilities will be paid at 70% coinsurance following deductible. Associated Travel expenses to Designated Transplant Facilities will be covered at 100% limited to $5,000 per calendar year. Acquisition/Procurement expenses at Designated Transplant Facilities will be covered at 100% of eligible expenses.

Covered expenses include:

a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
b. Services and supplies furnished by a Provider; and
c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs, including donor medical expenses, directly related to the procurement of an organ or tissue used in a transplant described herein will be covered up to $10,000 for each such procedure completed. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

15.01 Exclusions

Some health care services are not covered by the Plan. These include, but are not limited to, any charge for care, supplies, or services, which are:

1. **Abortion.** Expenses incurred directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise;
2. **Acupuncture.** Charges relating directly or indirectly to acupuncture;
3. **Biofeedback.** Biofeedback;
4. **Charges** for failure to keep a scheduled visit or charges for completion of a claim form;
5. **Cosmetic Surgery.** Charges for Cosmetic Surgery;
6. **Custodial Care.** Custodial Care, domiciliary care or rest cures, or home health care except as specifically provided herein;
7. **Education or Training Program.** Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
8. **Eye Lenses.** Eyeglasses and contact lenses;
9. **Gene Therapy.** Procedures, treatment, or prescriptions related to Gene Therapy;
10. **Growth Hormone Treatment**. Growth hormone therapy or other treatment for growth failure;
11. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness;
12. **Hearing Devices**. Hearing aids or examinations for the prescription or fitting of hearing aids;
13. **Hypnosis.** Expenses related to the use of hypnosis;
14. **Impregnation and Infertility Treatment.**
15. **Oral Surgery.** Oral Surgery or dental treatment, except as specifically provided in the Plan;
16. **Orthopedic Shoes.** Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge;
17. **Personal Convenience Items.** Equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician;
18. **Radial Keratotomy**. Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;
19. **Sex Change Operation.** Expenses related to a sex change operation or treatment of sexual dysfunction not related to organic disease;
20. **Travel.** Travel, whether or not recommended by a Physician, except as specifically provided herein; and
21. **Vitamins.** Vitamins and nutritional supplements.
22. **Weight Loss Programs**. Programs such as Optifast, Medifast, Weight Watchers, Diet Center, Jenny Craig.