AcuityGroup

Subscriber Information

IHA HEALTH

Employer: IHA Services, LLC
Group#: 3022L
Subscriber: First Name Last Name
Subscriber ID: XXXXXXXXX

Members Call: 866-888-6983 or
Email: iha@acuity-grp.com

Benefit Plan Information

In-Network

Deductible	Out of Pocket
Indiv: $3,500	Indiv: $6,550
Family: $7,000	Family: $13,100

Office Visit Copays (after deductible is met):
Primary Care | Specialist | Urgent Care - 20% coinsurance

Claims Submission & Network

Cigna.
Cigna PPO Network

To find a Cigna provider, visit
https://hcpdirectory.cigna.com

Providers:
DO NOT call Cigna directly for any reason.
Benefits are not insured by Cigna or affiliates.

SUBMIT MEDICAL CLAIMS:

MAIL: P.O. Box 188061
Chattanooga, TN 37422-8061

EDI PAYOR ID: 62308

CLAIMS MUST BE SENT TO
ADDRESS ABOVE FOR PROCESSING. "S"

Eligibility Verification

PROVIDERS: DO NOT CALL CIGNA DIRECTLY FOR ANY REASON.

TO VERIFY ELIGIBILITY, BENEFITS, CLAIM STATUS:

Call ACUITY GROUP Concierge (866) 888-6983 or visit our website at www.acuity-grp.com

For website login questions, email: acuityinfo@acuity-grp.com

Member Rx Information

RX BIN: 017274
RX PCN: PDMI
RX GRP: 99995820

TrueScripts.

Member Services: 844-257-1955
Prior Auth submit to: www.truescripts.com
Pharmacy Help Desk: 855-326-2159

Utilization & Review

Pre-cert is required for Inpatient/Outpatient hospitalization & services as specified in the plan.

For Pre-Cert: call (866) 888-6983

This card is for member identification purposes only. It does not guarantee coverage or benefits.

AWAY FROM HOME CARE

IHA 3500 CIGNA PPO HSA Plan

MEDICAL BENEFITS SCHEDULE

3022L	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED	
ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND PROCEDURE BASED MAXIMUM EXPENSE **Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers. The Network deductibles/maximum out-of-pockets ARE NOT applied to the Non-Network deductibles. The Non-Network deductibles/maximum out-of-pockets ARE NOT applied to the Network deductibles.**		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$3,500	$7,000
Per Family Unit	$7,000	$14,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (INCLUDES DEDUCTIBLE, COINSURANCE & COPAYMENTS)		
Per Covered Person	$6,550	$13,100
Per Family Unit	$13,100	$26,200
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over the Plan allowable fee Charges Ineligible amounts		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
COVERED CHARGES		
Hospital Services		
Room and Board	80% after deductible	60% of allowable fee after deductible
	Paid at the facility's semi-private room rate	
Intensive Care Unit	80% after deductible	60% of allowable fee after deductible
	Paid at the Hospital's ICU Charge	
Emergency Room Visit		

Emergency Room	80% after deductible	80% of allowable fee after deductible
Observation (less than 24 hours)	80% after deductible	60% of allowable fee after deductible
Outpatient Hospital/ Surgery Center	80% after deductible	60% of allowable fee after deductible
Skilled Nursing Facility	80% after deductible	60% of allowable fee after deductible
	Paid at the facility's semi-private room rate Limited to 60 days per benefit period maximum	
Urgent Care Services (Includes all charges)	80% after deductible	60% of allowable fee after deductible
Physician Services		
Inpatient visits	80% after deductible	60% of allowable fee after deductible
Primary Care Physician Office visits (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	80% after deductible	60% of allowable fee after deductible
Specialist office visits	80% after deductible	60% of allowable fee after deductible
Telemedicine – Preferred Vendor	100%	
Emergency Room Ancillary	80% after deductible	80% of allowable fee after deductible
Surgery	80% after deductible	60% of allowable fee after deductible
Anesthesia	80% after deductible	60% of allowable fee after deductible
Allergy testing, serum & injections	80% after deductible	60% of allowable fee after deductible

Diagnostic Services	80% after deductible	60% of allowable fee after deductible
Free Standing Laboratory Services	80% after deductible	60% of allowable fee after deductible
Free Standing Diagnostic Services (x-ray only)	80% after deductible	60% of allowable fee after deductible
Radiology (CT, PET, MRI, MRA, SPECT)	80% after deductible	60% of allowable fee after deductible
Home Health Care 60 visits per benefit period maximum	80% after deductible	60% of allowable fee after deductible
Hospice Care	80% after deductible	60% of allowable fee after deductible
Ambulance Service – ground/air	80% after deductible	80% of allowable fee after in- network deductible
Physical & Occupational Therapies	80% after deductible	60% of allowable fee after deductible
	Limited to 20 visits combined per benefit period maximum	
Speech Therapy	80% after deductible	60% of allowable fee after deductible
	Limited to 20 visits per benefit period maximum	
Cardiac Rehabilitation Therapy	80% after deductible	60% of allowable fee after deductible
	Limited to 36 visits per benefit period maximum	
Durable Medical Equipment (Limited to 12 month rental or purchase price, whichever is less)	80% after deductible	60% of allowable fee after deductible
Prosthetics & Orthotics	80% after deductible	60% of allowable fee after deductible
Spinal Manipulation Chiropractic (Includes x-rays)	80% after deductible	60% of allowable fee after deductible
	Limited to 20 visits per benefit period	
Mental Disorders/Substance Abuse		
Inpatient/Partial Hospitalization	80% after deductible	60% of allowable fee after deductible
	Paid at the facility's semi-private room rate	
Outpatient	80% after deductible	60% of allowable fee after deductible
Autism Spectrum Disorders		
Inpatient/Partial Hospitalization	80% after deductible	60% of allowable fee after deductible
	Paid at the facility’s average room rate for treatment	
Outpatient Visit	80% after deductible	60% of allowable fee after deductible
Preventive Care (Anything coded as Wellness)		
Routine Mammogram	100%	60% of allowable fee after deductible
	Limited to 1 per Calendar Year	

Routine Colonoscopy	100%	60% of allowable fee after deductible
	Limited to 1 per Calendar Year	
Routine Well Adult Care Includes chest x-ray and EKG	100%	60% of allowable fee after deductible

- Abdominal Aortic Aneurysm (Once per lifetime screening for men)
- Alcohol Misuse screening/counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults
- Depression screening
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for adults at higher risk
- Immunization vaccines: (Doses, ages, and recommended populations vary) Hepatitis A
  Hepatitis B Herpes Zoster
  Human Papillomavirus Influenza
  Measles, Mumps, Rubella Meningococcal
  Pneumococcal
  Tetanus, Diphtheria, Pertussis Varicella
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for higher risk
- Tobacco Use screening
- Syphilis screening for higher risk

Women's Preventive Care Servics	100%	60% of allowable fee after deductible

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women with higher risk
- Breast cancer Chemoprevention counseling for women at higher risk
- Breast Feeding intervention to support and promote breast feeding
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Folic Acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for pregnant women & follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling
- Syphilis screening for all pregnant women or women at higher risk
- Screening for gestational diabetes
- Human papillomavirus testing
- Counseling for sexually transmitted diseases
- Counseling for screening for human immune-deficiency virus
- FDA-approved female prescription contraceptive drugs and devices (e.g. diaphragm)
- FDA-approved female prescription contraceptive surgical procedures (e.g. IUD's)
- FDA-approved emergency contraceptive drugs
- Breastfeeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence

Routine Well Newborn Care (While hospital confined as a result of birth)	100%	60% of allowable fee after deductible

Routine Well Child Care	100%	60% of allowable fee after deductible
• Alcohol and Drug Use assessments for adolescents • Autism screening for children at 18 and 24 months • Behavioral assessments for children • Cervical Dysplasia screening for sexually active females • Congenital Hypothyroidism screening for newborns • Developmental screening for children under age 3, and surveillance throughout childhood • Dyslipidemia screening for children at higher risk for lipid disorders • Fluoride Chemoprevention supplements for children without fluoride in their water source • Gonorrhea preventive medication for the eyes of newborns • Hearing screening for newborns • Height, Weight and Body Mass Index measurements • Hematocrit or Hemoglobin screening for children • Hemoglobinopathis or sickle cell screening for newborns • HIV screening for adolescents at higher risk • Immunization vaccines: (Doses, ages, and recommended populations vary) Diphtheria, Tetanus, Pertussis Haemophilus influenzae type b Hepatitis A Hepatitis B Human Papillomavirus Inactivated Poliovirus Influenza Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Varicella • Iron supplements for children ages 6 to 12 months at risk for anemia • Lead screening for children at risk of exposure • Medical History for all children throughout development • Obesity screening and counseling • Oral Health risk assessment for young children • Phenylketonuria (PKU) screening for this genetic disorder in newborns • Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk • Tuberculin testing for children at higher risk of tuberculosis • Vision screening for all children		
Organ Transplants	80% after deductible (The Utilization Management Designated Transplant Network must be utilized)	60% of allowable fee after deductible
Implantable Devices	80% after deductible	60% of allowable fee after deductible
Note: Provider billing must include a manufacturer/wholesaler invoice for the implantable device.		
Prenatal/Postnatal Care	80% after deductible	60% of allowable fee after deductible
Inpatient Maternity Services (Room and Board charges limited to semi-private room rate) (Dependent daughter pregnancy is not covered)	80% after deductible	60% of allowable fee after deductible
Jaw Joint / TMJ (medical necessity required)	80% after deductible	60% of allowable fee after deductible

Orthopedic Shoes (Limited to specially molded and Medically Necessary shoes) (Limited to 1 paid per Covered Person per Calendar Year)	80% after deductible	60% of allowable fee after deductible
Diabetes Self-Management Education Program	80% after deductible	60% of allowable fee after deductible
Nutritional Counseling (Limited to 2 visits per Calendar Year, unless otherwise eligible under the Preventive Care Services)	80% after deductible	60% of allowable fee after deductible
Hearing Aids (medical necessity required. Covered under age 18 only.)	80% after deductible	60% of allowable fee after deductible
	Limited to $1,500 per hearing aid ($3,000 per pair) including repair/replacement, every 5 Calendar Years	
Routine Vision Exams (age 21 and over, limited to one exam per covered person per Calendar Year)	80% after deductible	60% of allowable fee after deductible
All Other Eligible Charges	80% after deductible	60% of allowable fee after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE

All copayments are after the deductible has been met

Pharmacy Option (1-30 day Supply)

Generic drugs
Copayment .....$15 copay after deductible

Brand Name
Copayment .....$65 copay after deductible

Non-Preferred Brand
Copayment .....$100 copay after deductible

Specialty Drugs
Tier 1 Copayment.....$100 copay after deductible

Tier 2 Copayment.....20% copayment to a $550 maximum

Tier 3 Copayment.....20% copayment to a $2,000 maximum

Tier 4 Copayment.....20%

Tier 5 Copayment.....50%

31-90 Day Pharmacy and Mail Order Options

Generic drugs
Copayment .....$45 copay after deductible

Brand Name
Copayment .....$90 copay after deductible

Non-Preferred Brand
Copayment .....$150 copay after deductible

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

*****Services are precertified based on precertification guidelines established by the Precertification vendor.**

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations
Inpatient Substance Abuse/Mental Disorder treatments
Home Health Care
Skilled Nursing Facility stays
Hospice Care
Durable Medical Equipment >$500
Physical, speech and/or occupational
Cardiac rehabilitation therapy
Outpatient surgical procedures (other than the physician's office)
MRI/MRA/CAT/PET scans
Observation > 23 hours
Chemotherapy / Radiation therapy
Organ transplant
Sleep Studies
Dialysis
Prosthetics/Orthotics >$500
Specialty & Select High Costs Prescription Drug Products **

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

A prior authorization is required for all Specialty Drugs, a list of which can be obtained by calling TrueScripts at (844) 257-1955. First time dispensing of a Specialty Drug may be limited to less than a 30-day supply when not prepackaged for a larger quantity. Additionally, a maximum unit of measure quantity limit per person/plan year may apply to some Specialty Drugs. Covered prescription injectable(s) and certain other specialty drugs such as chemotherapies may only be available through a designated specialty pharmacy. Specialty Drugs are categorized into the above Copay Tiers under Schedule of Benefits or as determined by TrueScripts' PDF Management Committee.

For specialty drug maximum unit of measure quantity limit coverage per person/calendar year and Specialty Drugs available through the Specialty Pharmacy contact TrueScripts Member Care Team at (844)-257-1955. Further, some Specialty Drugs may be excluded from a formulary Level. A Participant who is prescribed a Specialty Drug should contact TrueScripts Member Care at the above phone number to determine if the Specialty Drug is excluded from the Participant's Formulary Level and to determine if other Formulary Levels are available to the Participant that cover the Specialty Drug.

Medical Necessity Review

Chiropractic and PT / OT **Precertification for Chiropractic and Physical Therapy/Occupational Therapy (PT/OT) is defined as Medical Necessity Review (MNR) after the initial 5 visits and is only available for select geographies performed by participating providers in the American Specialty Health (ASH) network.**		
A "yes" or "no" selection MUST be made for each item in the Medical Necessity Review section	**Yes**	**No**
Chiropractic Services (Medical Necessity Review after the initial 5 visits for Participating Vendor Providers for Chiropractic Services)		X
Physical Therapy and Occupational Therapy (Medical Necessity Review after the initial 5 visits for Participating Vendor Providers for Physical Therapy and Occupational Therapy Services)	X	

Optional Precertification Buy-Up Categories • **Musculoskeletal and Pain Management (MSK) Program: A Per Employee Per Month (PEPM) fee is associated with this category.** • **Sleep Management Program (Eff 02/01/21): A Per Employee Per Month (PEPM) fee is associated with this category.** • **Oncology Management Program: An episode of care charge for a 12-month period is associated with this category per identified patient.** **Please refer to the Utilization Management At A Glance document.**		
A "yes" or "no" selection MUST be made for each category on this Snapshot."	**Yes**	**No**
Musculoskeletal and Pain Management (MSK) Program • Includes procedures performed in either an inpatient or outpatient place of service, depending on the procedure being performed; includes interventional pain management and major joint surgery. • Examples: Services that treat pain and discomfort in muscles, bones, and joints, including epidural steroid injections, facet injections, epidural adhesiolysis, spinal cord stimulators, pain pumps, radiofrequency ablation (RFA). Also includes surgical procedures for shoulder, hips, and knees.	x	
Sleep Management Program • Obstructive sleep apnea, diagnostic or therapeutic sleep studies	x	
Oncology Management Program • Oncology precertification program to review an oncology drug treatment regimen addressing the entire course of treatment for a member, as opposed to the drug-by-drug approval. • Uses proprietary algorithm review of member's entire oncology treatment plan, inclusive of medical infused medications, oral cancer medications, and support drugs. • Allows health care professionals to access the expert guidelines of 44 types of cancer treatment regimens defined by the National Comprehensive Cancer Network (NCCN) for compliance to their pathways guidelines. • Also includes precertification of Pharmacy oncology drugs should Cigna Pharmacy Benefits Management be included in the plan. ***Recommended for the management of high-cost specialty drugs***	x	

Inpatient Precertification

The categories below are outlined in the Cigna UM At A Glance document (Examples have been provided but are not inclusive of all services). All Inpatient categories are a required component of Cigna's UM program. Only Cigna can perform Utilization Management.

Acute Care- (Services rendered in the hospital setting not included in any other inpatient pre-cert category)
Routine and high risk maternity (routine only if inpatient stay exceeds federal requirements)
Long term acute care
Skilled Nursing Facility
Rehabilitation
Detox
IP Mental Health and Substance Abuse hospital
IP Mental Health and Substance Abuse residential

Outpatient Precertification

The categories below are outlined in the Outpatient Precertification Categories and the UM At A Glance documents. (Examples have been provided but are not inclusive of all services)

A "yes" or "no" selection MUST be made for each category on this Snapshot."	Yes	No
Cochlear Implants • Osseointegrated, cochlear or auditory brain stem implant	X	
Diagnostic radiology • CT scans, MRI/MRA, myocardial perfusion imaging, PET scans, cardiac blood pool imaging and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms	X	
Durable medical equipment/Orthotics & Prosthetics • Seat lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators • Helmets, extremity prosthetic additions, electric prosthetic joints, facial prosthesis provided by nonphysician, voice amplifiers, cranial remolding orthosis, lower extremity orthosis, knee brace	X (if cost over $500)	
Erectile dysfunction • Penile implants (does not include erectile dysfunction drugs)	x	
Gastric bypass • Gastrectomy, gastric restrictive procedures, lap sleeve, revision of stomach-bowel fusion	x	
Home Health Care (home nursing care) *Recommended for the management of high-cost specialty drugs* • Registered nurse, licensed practical nurse or aid in the home	x	
Home infusion therapy *Recommended for the management of high-cost specialty drugs*	x	

• Home infusion therapy for immunotherapy, continuous medications, hydration, total parenteral nutrition, pain management		
Injectable medications *Recommended for the management of high-cost specialty drugs* • Immune globulin, drugs for factor deficiencies, interferon, Rituxan, some chemotherapeutic agents, botox	x	
Oral pharynx procedures • Uvulectomy, LAUP procedures, palatopharyngoplasty (PPP), uvulopalatopharyngoplasty (UPP)	x	
Outpatient procedures (not otherwise categorized) *Does not include all outpatient surgeries* • Facial reconstruction, varicose vein treatment, breast reconstruction or reduction, blepharoplasty, rhinoplasty	x	
Potential experimental/investigational/unproven procedures *Recommended for the management of high-cost specialty drugs* • Keratoplasty, total disc arthroplasty, molecular pathology and gene analysis, air ambulance, private duty nursing, arthrodesis, external defibrillator, biologic implant	x	
Speech Therapy • Treatment and services of speech, language and voice. Can also be performed in the home setting	x	
Spinal procedures • Allograft/osteopromotive material for spine surgery, osteotomy, percutaneous vertebroplasty, arthrodesis, laminectomy, vertebral corpectomy, destruction by neurolytic agent, laminotomy, facet joint nerve destruction, spinal cord decompression	x	
Therapeutic radiology • Brachytherapy, proton beam therapy, radiotherapy	x	
Transplants *Required opt in with Cigna Lifesource Transplant Network* • Adult or pediatric, living or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants; preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants; transplant-related travel and lodging	x	
Unlisted procedures • Vascular surgery, miscellaneous DME, unclassified drugs/biologics including antineoplastics, lower extremity prosthesis	x	

GENERAL EXCLUSIONS AND LIMITATIONS

Note: Any treatment, charges, and/or medical provider reimbursement not covered by Reinsurance contract.

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) Abortion: Expenses for elective abortions will not be considered eligible

(2) Acupuncture. Services, supplies, care or treatment in connection with acupuncture.

(3) Adoption: Expenses related to adoption will not be considered eligible.

(4) After hours services. Additional charges, billed by the physician, for after hour, extended hour, or holiday services.

(5) Alcohol. Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. Also excluded for the Employee/Member only are charges for Injuries or Illnesses resulting from an accident where the Employee/Member is the driver and deemed to be under the influence of alcohol or drugs (DUI). This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.

(6) Alternative Medicine or Complementary Medicine: services and supplies related to alternative or complementary medicine, including but not limited to acupressure, acupuncture, aroma therapy, bioenergial synchronization technique (BEST), contact reflex analysis, holistic medicine herbal therapy, hypnotism, iridology (study of the iris), naturopathy, Reiki therapy, Rolfing, thermography, or other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine of the National Institutes of Health or any similar or successor organization;

(7) Autopsies: Expenses related to autopsies will not be considered eligible

(8) Autotransfusions. Charges for Autotransfusions or cell saver transfusions occurring during or after surgery.

(9) Biofeedback

(10) Blood or Other Body Tissue and Fluids, Including Storage. Blood, and the storage and banking of autologous and cord blood, body tissue and fluids

(11) Breast Surgery. Surgery for male breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.14 of this Certificate

(12) Close Relative: Expenses for services, care or supplies provided by a person who normally resides in the Covered Person’s home or by a Close Relative will not be considered eligible.

(13) Complications: Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible.

(14) Convenience/Comfort Items: Expenses for personal hygiene and convenience items will not be considered eligible.

(15) Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthotics of any sort, except

for diabetic foot orthotics, except as specified under the Schedule of Benefits and Medical Covered Charges section.

(16) Cosmetic Procedures: Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Schedule of Benefits and Medical Covered Charges section of the Plan.

(17) Counseling: Expenses for religious, marital, or relationship counseling will not be considered eligible, except as specified under Schedule of Benefits and Medical Covered Charges section of the Plan.

(18) Custodial Care: Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(19) Dentistry -The plan does not cover general dental services, defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include but are not limited to, restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, analgesia, other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures or any ancillary medical procedures required to support a general dental service. However, the plan will cover: a) expenses related to the emergency treatment of sound natural teeth as set forth in the document (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth), b) General Anesthesia and Associated Medical Costs as set forth in this document c) Impacted Wisdom Teeth as set forth in this document

(20) Developmental Delays: Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD and to expenses covered as a preventive service under the Schedule of Benefits and Medical Covered Charges section of the Plan.

(21) Devises or Computers: Expenses to assist in communication and speech

(22) Educational or vocational testing. Services for educational or vocational testing or training. This does not apply to any diabetic education that may be covered under the Plan.

(23) Employment, Insurance, or License related care. Physical exams or immunizations or any other treatment required for enrollment in any insurance program, as a condition of employment, for licensing, or other similar purposes. However, this exclusion does not apply to the Employer's health plan sponsored screenings.

(24) Exercise Programs: Exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(25) Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary. For Plan Years beginning on or after January 1, 2014, this exclusion shall not apply to the extent that the charge is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

(26) Eye care. Radial keratotomy, Lasik surgery or other eye surgery to correct vision problems that are alternately correctable by vision lenses. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting (unless specified in the Schedule of Benefits). This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered

under the well adult or well child sections of this Plan.

(27) Foot Care: Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible. Treatment (including cutting or removal) of toe nails or superficial lesions of the feet including corns, calluses and hyperkeratosis, other than removal of nail matrix or root, except when required to treat diabetes; or shoe orthotics, except when required to treat diabetes; electroshock wave therapy for treatment of plantar fasciitis, except to treat diabetes;

(28) Foot Orthotics, arch supports or other foot support devices, elastic stockings, garter belts or similar devices and orthopedic shoes including any casting or fitting charges except as stated in Schedule of Benefits and Medical Covered Charges section.

(29) Gleevec: Expenses for the prescription drug, Gleevec, will not be considered eligible.

(30) Governmental Agency: Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(31) Growth hormone therapy. Charges for growth hormone therapy.

(32) Hair Loss: Expenses for hair loss or hair transplants will not be considered eligible.

(33) Hearing Exams/Aids: Expenses for routine hearing examinations, hearing aids (including the fitting thereof), cochlear implants and supplies will not be considered eligible, except as otherwise covered under the Schedule of Benefits and Medical Covered Charges section of the Plan.

(34) Hazardous Hobby: Expenses for any condition, Illness or Injury, or complication thereof, arising out of engaging in a hazardous hobby or activity will not be considered eligible. For the purposes of this Plan, "hazardous hobby or activity" is defined as an unusual activity characterized by a constant threat of danger, such as skydiving, auto racing, hang gliding, bungee jumping. This does not include common recreational activities, such as water or snow skiing, jet skiing, horseback riding, boating, motorcycling, snowmobiling, all-terrain vehicle riding and team sports.

(35) Holistic Treatment Expenses for holistic treatment including acupressure, acupuncture, aromatherapy, hypnotism, alternative therapy (art, music, dance, horseback) and Rolfing will not be considered eligible.

(36) Homeopathic Treatment: Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(37) Hyperhidrosis: Expenses related to surgical treatment of excess sweating will not be considered eligible

(38) Hypnotherapy: Expenses for hypnotherapy will not be considered eligible.

(39) Illegal acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of an Illegal Act, or a riot, or public disturbance. For purposes of this exclusion, the term Illegal Act shall mean any act or series of acts that, if charged, prosecuted and convicted of a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.

(40) Illegal Occupation/Felony: Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(41) Impotence. Care, treatment, services, supplies or medication in connection with treatment for impotence.

(42) Late submission. Charges for care, treatment, services or supplies which were incurred more than 12 months prior to the date the charges were submitted to the Plan for payments

(43) Learning disabilities. Care, supplies, and services for the treatment of autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.

(44) Maintenance Therapy: Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(45) Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.

(46) Massage Therapy: Expenses for massage therapy will not be considered eligible.

(47) Medically Necessary: Expenses which are determined not to be Medically Necessary will not be considered eligible.

(48) Missed Appointments: Expenses for completion of claim forms, missed appointments, cancelled appointments, or telephone consultations will not be considered eligible, except as shown in the Scheduled of Benefits.

(49) Motor vehicle injury. Charges incurred for the care or treatment of any injury sustained as a result of or related to any motor vehicle accident to the extent that such care or treatment for that injury is covered by any plan, program, policy or other arrangement providing insurance coverage for vehicles. Injury while driving or riding in any organized automobile or motorcycle race or speed contest

(50) Negligence: Expenses for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician will not be considered eligible.

(51) Never Events: Expenses for serious preventable adverse events ("Never Events") will not, in any event, be considered eligible. These Never Events include:

(a) Surgery performed on the wrong body part;

(b) Surgery performed on the wrong patient;

(c) Wrong Surgical procedure performed on a patient;

(d) Unintentional retention of a foreign object in a patient after Surgery or other procedure;

(e) Inoperative or immediate postoperative death in an ASA Class I patient;

(f) Patient death or serious disability associated with the use of contaminated Drugs, devices, or biologics provided by the healthcare facility;

(g) Patient death or serious disability associated with the use or function of a device in a patient in which the device is used for functions other than as intended;

(h) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility;

(i) Patient death or serious disability associated with patient leaving the facility without permission;

(j) Patient suicide, or attempted suicide resulting in a serious disability, while being cared for in a healthcare facility;

(k) Infant discharged to the wrong person;

(l) Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparations, or wrong route of administration);

(m) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;

(n) Maternal death or serious disability associated with labor and delivery in a low-risk Pregnancy while being cared for in a healthcare facility;

(o) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility;

(p) Death or serious disability associated with failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns;

(q) Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility;

(r) Patient death or serious disability due to spinal manipulative therapy;

(s) Artificial insemination with the wrong donor sperm or wrong egg;

(t) Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility;

(u) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

(v) Patient death or serious disability associated with a burn Incurred from any source while being cared for in a healthcare facility;

(w) Patient death associated with a fall while being cared for in a healthcare facility;

(x) Patient death or serious disability associated with the use of restrains or bedrails while being cared for in a healthcare facility;

(y) Any instance of care ordered by or provided by someone impersonating a Physician, nurse, pharmacist, or other Provider;

(z) Abduction of a patient of any age;

(aa) Sexual assault on a patient within or on the grounds of a healthcare facility; and

(bb) Death or significant Injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility.

(52) No Legal Obligation: Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.

(53) Non-Covered Procedures: Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(54) Non-Covered by Medicare or Medicaid: services, supplies or drugs not approved for reimbursement by the Centers for Medicare and Medicaid Services or any successor organization;

(55) Not Performed Under the Direction of a Physician: Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(56) Not Recommended by a Physician: Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(57) Nutritional Supplements: Expenses for nutritional supplements, vitamins, and mega-vitamins or other enteral supplementation will not be considered eligible, except as specified under Schedule of Benefits and Medical Covered Charges of the Plan. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(58) Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversal unless otherwise stated in the Schedule of Benefits for Morbid Obesity.

(59) Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(60) Off-label drugs. A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(61) Operated by the Government: Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(62) Oral Nutrition Products or Supplements. Oral nutrition products or supplements used to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, obesity, hypo or hyper-glycemia, gastrointestinal disorders, etc., including, but not limited to, lactose free foods; banked breast milk; and/or standardized or specialized infant formulas.

(63) Orthopedic Therapies: Expenses for acupuncture will not be considered eligible.

(64) Outside the United States (U.S.): Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.

(65) Over-the-Counter (OTC) Medication: Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive services under the Schedule of Benefits and Pharmacy Covered Charges section of the Plan.

(66) Personal comfort items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(67) Personal and Athletic Trainer Services. Services provided by a personal or athletic trainer

(68) Plan design excludes. Charges excluded by the Plan design as mentioned in this document.

(69) Plan Maximums: Charges in excess of Plan maximums will not be considered eligible.

(70) Plan Allowable Fee: Expenses in excess of the Plan allowable fee charge will not be considered eligible.

(71) Podiatric orthotics. Over the counter or custom made shoes, shoe inserts, arch supports and other foot orthotics to control foot function, except as specified under the Schedule of Benefits and Medical Covered Charges section.

(72) Prior to Effective Date: Expenses which are incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(73) Private Duty Nursing: Expenses for inpatient private duty nursing will not be considered eligible except as otherwise stated in the “Covered Services” section of this document.

(74) Radioactive Contamination: Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(75) Radiation Therapy: Expenses for services for dermatitis or similar skin conditions

(76) Recreational and Educational Therapy: Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

(77) Refractive Errors: Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible, unless otherwise stated in this document.

(78) Relative giving services. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law

(79) Replacement of Component Parts or Modification of a Prosthetic Device within five (5) years of obtaining a new or other replacement part(s) unless incident to the Member's growth for a Member who is under the age of nineteen (19) years.

(80) Required by Law: In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(81) Reversal of Genital Surgery. Surgical procedures to reverse genital surgery

(82) Riot/Revolt: Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(83) Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventative medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(84) Safety devices. For drivers and all passengers: charges for the treatment for injuries incurred when not wearing appropriate safety restraints and/or motorcycle helmets, when legally required.

(85) Screening exams. Charges for exams required by an insurance company to obtain insurance, required by a governmental agency, or required by an employer in order to begin or continue working.

(86) Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(87) Self-Inflicted Injury: Expenses for Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury will not be considered eligible. This exclusion will not apply if self-inflicted Injuries result from a medical condition (physical or mental) or act of domestic violence and the benefits for such Injuries are normally covered under the Plan.

(88) Sex Transformation: Expenses in connection with sex transformation will not be considered eligible.

(89) Sexual Dysfunction/Impotence: Expenses for services, supplies or drugs related to sexual dysfunction/impotence not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.

(90) Speech Therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

(91) Stand-by Physician: Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(92) Sterilization: Expenses for the reversal of elective sterilization will not be considered eligible.

(93) Surgery for the Jaw: Expenses for orthognathic will not be considered eligible.

(94) Surrogate: Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.

(95) Telephone. Charges for telephone or email completion of claim forms, or any charges associated with missed appointments.

(96) Third Party Responsible: expenses related to a Sickness or Injury for which a third party is or may be responsible, unless such expenses are advanced as provided in the provision entitled Subrogation.

(97) Transportation Services. Stretcher van and/or wheelchair van transportation services

(98) Travel: Expenses for travel will not be considered eligible, except as specified under Schedule of Benefits and Medical Covered Charges.

(99) Vivo or In Vitro fertilization: Expenses for any other fertilization procedure, test, treatment or drug;

(100) Vision Therapy: Expenses for vision therapy will not be considered eligible

(101) Wage or Profit: Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

(102) War: Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(103) Weight Loss: Surgical and non-surgical care and treatment of obesity and/or morbid obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service under the Schedule of Benefits and Medical Covered Charges section of the Plan. Exclusion does not apply Morbid Obesity benefit, listed in Schedule of Benefits.

(104) Weekend Admissions: Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(105) Worker's Compensation: For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability, Own Occupation, Occupational Accident or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar State or Federal law and does not have such coverage. Proof of waiver of coverage will be required for those members eligible who waived or not enroll based on the State and/or Federal law.