MEDICAL BENEFITS

Fund Name: **IBEW/WU Health and Welfare Trust Fund**

Fund ID: **P700**

SPD Version: January 2014
Revised: 10/31/2024 TW
Spyglass Live Date: 7/25/2024

Who is covered? Active Members & Dependents.
Members enrolled in the HMO Kaiser plan can elect Dental & Vision.
Only Local 125 members can elect Kaiser HMO plan

Trust Fund Office Contact Information:
Phone (925)398-7050 or (855)617-2478

To access eligibility, claims status and summary of benefits for medical, dental and/or vision as well as to contact the Trust Fund Office for general questions, visit our Provider Portal at **memberbenefitsonline.com**
or email Websupport at
Members: staff@ibew-west.com
Providers: P700_provider@benesys.com

Correspondence Mailing Address:
Po Box 215
San Ramon, CA 94583

PPO Network: Cigna OAP Network
Group #: 3336513

Claims Address: Cigna
Po Box 188004
Chattanooga, TN 37422-8004
Payor ID: 62308

Non-PPO Providers should submit claims to CIGNA with the group# 3336513. CIGNA will price all Out-of-Network Claims.

Cigna: Phone (800)768-4695
Cigna Provider Pricing Disputes: (800) 549-8908
www.cigna.com

Prior Authorization & Case Management
Inpatient and Outpatient Pre-cert - CareAllies: (800) 768-4695
CT Scans, MRI, PET scans, and MSK (Musculoskeletal Surgery) - Eviocore: (866) 249-3808
Home Health, DME & Home Infusion Pre-cert - CareAllies: (800) 768-4695
All States but Oregon: **Physical & Occupational Therapy - ASH**: (800) 848-3555
Oregon: **Physical & Occupational Therapy CareAllies** - (800) 768-4695

Cigna Provider Appeal Provider Contact Info
Retro Review: (866) 729-2460
Appeals: (877) 830-8833
Phone Number to call for status: (800) 768-4695

Mental Health/Substance Abuse/EAP Services PPO Network:

Cigna Behavioral Health

Phone (877) 622-4327
mycigna.com
Employer ID: westernutilities

H.S.A. Administrator: Health Equity

(Consumer Driven Health Plan Participants only)

Phone (866)346-5800
www.myhealthequity.com

Online Office Visits: MDLIVE Cigna Virtual Care

Via mycigna.com click “Connect Now” to talk to a doctor or nurse 24/7 or connect via Phone at (888) 726-3171

Connect with doctors, pediatricians, counselors, and psychiatrists. Prescriptions will be sent directly to local pharmacy, if appropriate.

<table>
<tr><td colspan="3"><u>SPECIAL REIMBURSEMENT PROVISIONS (NETWORK)</u> :
(Amendment 1, Pg. 17)
The Fund will pay as if the care was provided In-Network including deductible, coinsurance, copays and OOP Maximums/Limits and the allowance for bills will be reimbursed according to the Allowed Charge allowance for non-network providers if there is no in-network facility/provider qualified by area of professional specialty or practice available to provide Medically Necessary eligible health services.

(Amendment 7, Pg. 19)
Ancillary services (including but not limited to professional fees related to radiology, anesthesia, pathology, lab, emergency room physician, assistant surgeon) received from an out-of-network provider in connection with a visit to or surgery or service performed by an in-network provider, if the choice of the out-of-network provider who performed the service was out of the patient's control will process with in-network benefit levels at the out-of-network allowance.
PLEASE NOTE: "Ancillary" services do not include "ambulance services"</td></tr>
<tr><td colspan="3">If Member uses another insurance to purchase prescriptions, the Plan will reimburse the copay through Medical.</td></tr>
<tr><td>90, PM, SMM 9/19, Ticket 245460, Ticket 281148</td><td colspan="2"><u>Prior Authorization by Cigna</u>:
The Plan follows Cigna's prior authorization guidelines. A copy of Cigna's prior authorization lists is available to view here. Please refer participants/providers to Cigna directly for inquiries related to prior authorization as they have the most current prior authorization lists available.

Outside of Cigna's prior authorization guidelines, Effective August 6, 2022, the Plan requires all Physical & Occupational Therapy to have prior authorization after the 4th visit. The Prior authorizations for PT/OT are completed by either Cigna or ASH depending on the state the member lives in.
The list by states can be found here.

The following providers do not require prior authorization per their contract with Cigna: Intermountain Health Care Hospitals (IHC) #94-2854057 & ASH Physical Therapists #56-2403146, #45-5513255, #45-5492777, #47-5409608, #33-0571188.

RETRO REVIEW: If precertification is not obtained for services that require precertification, the claim will deny. The Provider can request a retro precertification; however, there will be a precertification penalty of $200 applied to any out-of-network claims that require retro precertification.</td></tr>
<tr><td>22-23</td><td>Health Savings Account (HSA) Requirements
(CDHP Participants Only)</td><td>IRS guidelines define a HSA Eligible individual as a person who:

• Is covered under a HSA-qualified high deductible health plan, and
• Has "no other coverage" (except what is permitted by the IRS), and
• Is not enrolled in Medicare, and
• Cannot be claimed as a dependent on someone else's tax return.

"No other coverage" means you cannot also be covered under your spouse's medical plan or by any general-purpose Health Flexible Spending Account (Health FSA), any general-purpose Health Reimbursement Account (HRA) or covered by another plan that pays medical benefits.

HSA Account for Dependent Child Expenses: The IRS requires that a HSA account holder must be able to claim the child as a dependent on their tax return in order to use HSA funds to reimburse eligible medical expenses for the dependent child.</td></tr>
</table>

135-139	**Coordination of Benefits**	Please refer to the separate Coordination of Benefits Outline for the Consumer Drive Health Plan. When this Plan pays second, it will pay up to 100% of "Allowable Expenses" less whatever payments were actually made by the primary plan(s). This Plan will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first. "Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person. **Coordination with Medicare:** **If the participant is eligible for, but is not enrolled in, Medicare, this Plan pays the same benefits provided for active participants less the amounts that would have been paid by Medicare had the participant been covered by Medicare.** **When the Plan is secondary to Medicare the Plan pays the same benefits provided for Active Participants less any amounts paid by Medicare, based on the Medicare Allowable.** **NOTE: The IBEW/WU Health & Welfare Plan's Deductible must be met each Calendar Year prior to the Plan paying benefits.**

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
22	**Deductible**	Services that do not have a copay, deductible will apply unless otherwise stated. The Deductible from In-Network and Out-of-Network providers are combined to meet your annual Deductible.							
		$2,500 per person $5,000 family	$5,000 per person $10,000 family	$300 per person $900 family	$600 per person $1,800 family	$250 per person $750 family	$500 per person $1,500 family	$250 per person $750 family	$500 per person $1,500 family
23 Amd8, OE2017	**Out-of-Pocket (OOP) Coinsurance Maximum**	Prescription Drug OOP expenses will be included in the Medical Plan OOP Maximum for ALL Plans. Out-of-network emergency services performed in an emergency room will accumulate towards the in-network out-of-pocket maximum. Once the OOP Max is met for the CDHP, claims pay at 100%. Once the OOP Max is met for all other plans in-network claims pay at 100%.							
		$6,450 per person $12,900 family	No out-of-pocket limit	$2,000 per person $4,000 family	No out-of-pocket limit	$1,000 per person $2,000 family	No out-of-pocket limit	$500 per person $1,000 family	No out-of-pocket limit

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Cost Sharing Maximum	Includes copayment, medical/prescription plan coinsurance & deductibles for all Plans except the Consumer Driven Health Plan.							
		N/A	N/A	$6,600 per person $13,200 family	N/A	$6,600 per person $13,200 family	N/A	$6,600 per person $13,200 family	N/A
Amd6, OE2017	**Annual Maximum**	None							
	Full Time Students	Dependents Covered to age 26.							
	Exclusions	See Exclusions Worksheet.							
	Timely Filing Limits	One year from the date of service.							
	Authorized Providers	MD, DO, OD, Licensed Health Care Practitioner, and Physician's Assistant.							
11	**Pre-existing Clause**	None							
	Abortion	Termination of pregnancy is covered only when attending Physician certifies that the female's health would be endangered if the fetus were carried to term or where complications arise from an abortion (DNC).							
	Accident	Work Related - Not Covered. We will not withhold payments for accident claims that do not exceed $2,500 in total.							
101	*Motor Vehicle*	The Motor Vehicle coverage pays first, and this Plan pays second, whether the vehicle is insured or not. Request for a Signed Lien Agreement but will not withhold payments for claims that do not exceed $2,500 in total.							
		80%	50%	90%	50%	90%	50%	90%	50%
62	*Fights*	Not Covered		Not Covered		Not Covered		Not Covered	
	Acupuncture	Payable to a maximum of $500 per person per calendar year. The benefit limit does not apply to acupuncture used as a treatment for Tobacco Cessation.							
	Acupuncture	80%	50%	90%	50%	90%	50%	90%	50%
	Allergy Testing	80%	50%	90%	50%	90%	50%	90%	50%
	Injections	80%	50%	90%	50%	90%	50%	90%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
NSA	**Ambulance**	Ground Vehicle Ambulance services are covered only when those services are for an Emergency. Air transportation only when medically necessary. • Ground ambulance is paid at the designated benefit level by Plan (see below) • IN NETWORK - If ambulance is contracted with Cigna • OUT OF NETWORK - Non contracted with Cigna - For OON ground ambulance CIGNA prices using MCR - • Patient can still be billed for the amount over the MCR pricing from Cigna • "BUMP UP RULE" – there is no bump rule for the Plan that would reduce the patient responsibility if the CIGNA MCR pricing is used. The Provider remains OON with CIGNA so they can charge the patient the amount over the CIGNA MCR pricing + any coinsurances due • "Ancillary" services do not include "ambulance services". EFFECTIVE 1/1/2022 NO SURPRISE ACT – Air Ambulance: Out of Network Providers will pay at the IN-Network rate and these services will be processed using **QPA (Qualified Payment Amount).**								
	Ground	80%	50%	90%	90%	90%	90%	90%	90%
	Air	80%	50% Eff. 1/1/22: 80%	90%	90%	90%	90%	90%	90%
129, PM	**Appeal Procedure**	Before a participant appeal can be heard by the Board of Trustees, the appeal must first be made to Cigna. If Cigna denies the appeal, it can then be heard by the Board of Trustees. Please instruct members that wish to appeal to include the denial from Cigna with their appeal letter and supporting documents when they send them into the Trust Fund Office. Appeal timely filing is 180 days.							
	Birth Control	See Routine Preventive Section.							
	Blood Transfusions	80%	50%	90%	50%	90%	50%	90%	50%
	Chiropractic	$50 per visit not to exceed $500 per person/per year. Providers contracted with Healthways MUST submit claims to: Healthways WholeHealth Networks, Inc. PO BOX 3192, Milwaukee, WI 53201 If claims are submitted to Cigna from a Healthways provider, the claims will not be forwarded or priced. Providers having issues with billing should contact Cigna directly, however if they are not getting resolution, the number for Healthways is 877-561-5862, or we can reach out to our Cigna rep.							
	Exam	80%	50%	90%	50%	90%	50%	90%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Manipulations	80%	50%	90%	50%	90%	50%	90%	50%
	X-rays	80%	50%	90%	50%	90%	50%	90%	50%
	Massage	Not Covered		Not Covered		Not Covered		Not Covered	
	Clinical Trials	Routine Costs Related to Clinical Trial Participation are covered per government guidelines and coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan. Please see SPD for further details.							
	Consultations	80%	50%	100% $25 copay	50%	100% $20 copay	50%	100% $10 copay	50%
	Specialist Office Visit	80%	50%	100% $50 copay	50%	100% $20 copay	50%	100% $10 copay	50%
64	**Court Order**	Not Covered		Not Covered		Not Covered		Not Covered	
65	**Dental**	Not Covered		Not Covered		Not Covered		Not Covered	
SPD Pg 47, 68, 88	*Dental Oral, Craniofacial and TMJ Services*	Covered Services: Alveolar Ridge reconstruction (appropriate documentation that the patient has been wearing Dentures for at least 10 years). Accidental injury excludes damage from chewing/biting, treatment must be within 2 years of an injury TMJ max $5,000 per person per lifetime Oral Craniofacial removal of tumors/cysts. Orthognathic surgery for the treatment of prognathism/retrognathism - Eligible dental services resulting from Medically Necessary orthognathic surgery has maximum of $10,000 per person per calendar year/$25,000 per person per lifetime.							
		80%	50%	90%	50%	90%	50%	90%	50%
90, 102, 163, PM	**DME**	Sleep apnea mouth guards are not covered. 5 year replacement period. See Routine Section for Breast Pump benefits.							
		80%	50%	90%	50%	90%	50%	90%	50%
	Dialysis	80%	50%	90%	50%	90%	50%	90%	50%
	Diagnostic X-rays & Labs								
		80%	50%	90%	50%	90%	50%	90%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
Amd 7, NSA	**Emergency Care**	Copay waived, if admitted. Out-of-Network emergency room services are payable at the In-Network level, only if the treatment is for an emergency. ER Services for Out-of-Network providers count toward the Out-of-Pocket Maximum for the Consumer Driven Health Plan. Effective 5/1/16, ancillary services received from an out-of-network provider (outside the patient's choice) in connection with a visit to, surgery or serviced performed by an in-network provider will process with in-network benefit levels with the out-of-network allowance. **EFFECTIVE 1/1/2022 NO SURPRISE ACT - Emergency Definition:** An emergency medical condition, means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. An emergency service means (1) an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department. **EFFECTIVE 1/1/2022 NO SURPRISE ACT- For Emergency Care (Not Urgent Care) -** Out of Network Providers will pay at the IN-Network rate and payments will be processed using **QPA (Qualified Payment Amount).**								
	ER Facility Accident	80%	80%	100% $250 copay	100% $250 copay	100% $100 copay	100% $100 copay	100% $100 copay	100% $100 copay
	ER Facility Illness	80%	80%	100% $250 copay	100% $250 copay	100% $100 copay	100% $100 copay	100% $100 copay	100% $100 copay
	ER Physician	80%	80%	100%	100%	100%	100%	100%	100%
	Ancillary/x-ray/lab	80%	80%	100%	100%	100%	100%	100%	100%
	Urgent Care Facility	80%	50%	100% $50 copay	50%	100% $50 copay	50%	100% $50 copay	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Urgent Care Physician	80%	50%	100%	50%	100%	50%	100%	50%
	Extended Care Facility	See Skilled Nursing Benefits.							
64	**Foot Care (Routine)**	Corrective shoes or supportive devices for the feet including orthotics are not payable unless they are an integral part of a lower body brace.							
	Exam	80%	50%	100% $50 copay	50%	100% $20 copay	50%	100% $10 copay	50%
	Surgery	80%	50%	90%	50%	90%	50%	90%	50%
SPD Pg 43, 64, 84	**Genetic Testing**	Genetic testing requires pre-certification (ACA preventive genetic testing services do not require pre-certification)							
		80%	50%	90%	50%	90%	50%	90%	50%
	Hearing Benefits	$500 maximum per person every 3 years for fitting, repairs, and hearing aid devices. Dependent children with an audiology exam revealing bilateral hearing of 30 decibels or greater, the Fund allows an additional payment up to $1,500 per person every 3 yrs. coverage is provided for Cochlear implants for children (in addition to the $500 max total $2,000).							
	Device	80%	50%	90%	50%	90%	50%	90%	50%
	Cochlear implant	80%	50%	90%	50%	90%	50%	90%	50%
	Dependent benefit								
	Home Health Care	100 visits per person per calendar year. (This includes Skilled Nursing Care, Home Health Care, Home Infusion and Home Aid).							
	Home Health	80%	50%	90%	50%	90%	50%	90%	50%
	Home Infusion	80%	50%	90%	50%	90%	50%	90%	50%
	Hospice	$15,000 max per person per lifetime. The Fund covers 8 days of Respite care during a Hospice benefit. Bereavement counseling beyond that is included as part of the Hospice program is payable under Mental Health.							
	In/Out Patient Care	80%	50%	90%	50%	90%	50%	90%	50%
	Respite Care	80%	50%	90%	50%	90%	50%	90%	50%
	Bereavement	80%	50%	90%	50%	90%	50%	90%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
26	**Hospital Services**	**EFFECTIVE 1/1/2022 NO SURPRISE ACT** - FOR SERVICES RENDERED IN AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER, NON-PARTICIPATING PROVIDERS SUCH AS ANESTHESIA, ANESTHESIOLOGIST, PATHOLOGY, RADIOLOGY, NEONATOLOGY, DIAGNOSTIC SERVICES, ASSITANT SURGEON, HOSPITALIST, AND INTENSIVIST SERVICES. THESE NON-PARTICIPATING PROVIDERS CANNOT BALANCE BILL AND MAY NOT ASK PATIENTS TO GIVE UP PROTECTIONS NOT TO BE BALANCE BILLED. These Services will pay at the IN-Network rate and payments will be **processed using QPA (Qualified Payment Amount).**							
	R & B (Semi-Private)	80%	50%	90%	50%	90%	50%	90%	50%
	Private Room (only when medically necessary or facility doesn't provide Semi-Private)	80%	50%	90%	50%	90%	50%	90%	50%
	Ancillary Services	80%	50%	90%	50%	90%	50%	90%	50%
	ICU/CCU	80%	50%	90%	50%	90%	50%	90%	50%
	Lab/X-rays	80%	50%	90%	50%	90%	50%	90%	50%
	Physicians	80%	50%	90%	50%	90%	50%	90%	50%
65	**Infertility**	Not Covered		Not Covered		Not Covered		Not Covered	
	Injections	80%	50%	90%	50%	90%	50%	90%	50%
	Maternity	**Dependent Daughter:** Only expenses related to a complication of a pregnancy, and routine preventive services of a Dependent Child are payable. **Hospital Length of Stay for Childbirth:** The Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).							
	Pre/Post Natal Care	100%	50%	100%	50%	100%	50%	100%	50%
	Delivery	80%	50%	90%	50%	90%	50%	90%	50%
	New Born Care	80%	50%	90%	50%	90%	50%	90%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Midwife	80%	50%	90%	50%	90%	50%	90%	50%
	Dependent Daughter	Covered expenses are limited to preventive services under PPACA (pre/post-natal preventive care) and complications of pregnancy.							
		80%	50%	90%	50%	90%	50%	90%	50%
	Genetic testing Amnio/CVS/AFP	80%	50%	90%	50%	90%	50%	90%	50%
SPD Pg 45, 48, 66, 69, 86, 89	*1 Routine Ultrasounds per pregnancy. Additional may require Precertification.*	80%	50%	90%	50%	90%	50%	90%	50%
149	**Mental Health**	Contact **Cigna Behavioral Health at (877) 622-4327.** Per Consultant: Although Outpatient Mental Health does not require precertification, we still want to steer people to Cigna Behavioral Health for all EAP/Behavioral Health issues. We want them to use their 8 free EAP visits before seeking outpatient care. And, we prefer to have the EAP/BH provider direct them to the best provider for their specific condition. Members may also use these services for counseling for Tobacco addiction BENEFITS ARE PAYABLE ONLY FOR SERVICES OF BEHAVIORAL HEALTH CARE PRACTITIONERS - A psychiatrist, psychologist, or a mental health counselor or social worker who has a Master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling or child of the patient. RESIDENTIAL TREATMENT PROGRAM/FACILITY/CARE - is a non-acute hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan a facility must be licensed as a residential treatment facility and contracted with the PPO Network. Licensure requirements for this residential level of care may vary by state. ABA THERAPY – is payable when performed by a practitioner who is a Board-Certified Behavior Analyst certified to perform behavioral assessments, design and supervision of behavior analytic interventions including supervision of board-certified associate/assistant behavior analysts.						
		1. When the member decides they want to see a mental health provider, they, or their Provider call E-MAP, get a referral to a provider in their area and the first 8 visits are all handled through them, paid at 100%. We will not see any of this on our end. 2. If, after the first 8 visits, it is determined that the member wants or needs continued care, they or their provider contact **Cigna Behavioral Health at (877) 622-4327**. Cigna will send us the authorization information and it is noted on F6.							

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Inpatient	80%	50%	90%	50%	90%	50%	90%	50%
PM	*Partial Hospitalization/ Day Treatment*	80%	50%	90%	50%	90%	50%	90%	50%
Amd1	*Residential Treatment Facility*	80%	Not Covered	90%	Not Covered	90%	Not Covered	90%	Not Covered
	Outpatient	80%	50%	100% $25 copay	50%	100% $20 copay	50%	100% $10 copay	50%
	Testing	80%	50%	90%	50%	90%	50%	90%	50%
	Chronic pain control Pain Rehabilitation	80%	50%	90%	50%	90%	50%	90%	50%
Amd 4	**Nutritional Counseling** 5 visits covered per year	Nutritional Counseling - Limited to 5 visits per year Effective 1/1/16: Visit limitations do not apply when services are medically necessary for the treatment of an individual diagnosis with mental health or substance abuse condition.							
		100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
68, Amd 4	**Obesity**	**NON-PREVENTIVE OBESITY SERVICES – ARE NOT COVERED!!!!** **For Preventive Obesity Service Guidelines ONLY:** Effective 1/1/16, covered if only the following requirements are met: Not Covered except, for adults (1) with a body mass index of 30 kg/m² or higher, or (2) who are overweight (defined as a BMI of 25-29.9 kg/m²) or obese (defined as a BMI of 30 kg/m² or higher), AND have additional cardiovascular disease (CVD) risk factors. The plan covers Physician prescribed intensive behavioral counseling interventions, up to a combined limit of 26 individual or group visits per 12-month period by an in-network provider. For children ages 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician. **Cardiovascular examples Include but not limited to**- coronary artery disease (CAD), heart attack, stroke, heart failure, high blood pressure (hypertension), peripheral artery disease (PAD), arrhythmia, congenital heart defects, aortic aneurysm and rheumatic heart disease.							
Amd 4	*Preventive Obesity (See above requirements)*	100%	50%	100%	50%	100%	50%	100%	50%
99	***Non-Preventive Obesity Services***	**ALL NON-PREVENTIVE OBESITY SERVICES ARE NOT COVERED** ***(INCLUDING: Gastric Bypass, Gastric Sleeve, Duodenal Switch)***							

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Office Visits	**Primary Care Physician** means a Physician or other Health Care Practitioner who practices general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). ALL other Physicians are considered specialists under this Plan.							
		80%	50%	100% $25 copay	50%	100% $20 copay	50%	100% $10 copay	50%
PM, Ticket 275625	*MDLIVE Cigna Virtual Care*	NOTE: Cigna will place a hold on patient's credit card when services are rendered. This will be removed when BeneSys pays the claim. If there is a cost share applied (CDHP), the card will not be charged until BeneSys pays the Fund's portion, then the 20% coinsurance will be billed.							
		100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Ticket 232910, Amd 6	*Telehealth (includes Mental Health)*	80%	Not Covered	100% $25 copay	Not Covered	100% $20 copay	Not Covered	100% $10 copay	Not Covered
PM	*Onsite Care Clinic*	$55	Not Covered	100% $25 copay	Not Covered	100% $20copay	Not Covered	100% $10 copay	Not Covered
	Penile Implants	Not Covered		Not Covered		Not Covered		Not Covered	
	Podiatry	See Foot Care							
SPD Pg 104	**Private Duty Nursing**	Not Covered							
	Prosthetics	Replacements once every 5 Years.							
		80%	50%	90%	50%	90%	50%	90%	50%
66	*Wigs*	Not Covered		Not Covered		Not Covered		Not Covered	
	Routine Preventive	Physical once per year not covered for school, sports, camp, work etc.							
Ticket 174584		**Special Preventive Services Covered Only Under the Consumer Driven Health Plan (with H.S.A.)**							
	Angiotensin Converting Enzyme (ACE) inhibitors	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Anti-resorptive therapy	100%	Not Covered	Not Covered		Not Covered		Not Covered	

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Beta-blockers	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Blood pressure monitor	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Inhaled corticosteroids	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Insulin and other glucose lowering agents	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Retinopathy screening	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Peak flow meter	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Glucometer	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Hemoglobin A1c testing	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	International Normalized Ration (INR) testing	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Low-density Lipoprotein (LDL) testing	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Selective Serotonin Reuptake Inhibitors (SSRIs)	100%	Not Covered	Not Covered		Not Covered		Not Covered	
	Statins	100%	Not Covered	Not Covered		Not Covered		Not Covered	
		Adult Preventive							
	Physical Exams	100%	50%	100%	50%	100%	50%	100%	50%
	Abdominal aortic aneurysm Screening (Men ages 65-75 who have ever smoked)	100%	50%	100%	50%	100%	50%	100%	50%
	Alcohol Misuse Screening & Counseling	100%	50%	100%	50%	100%	50%	100%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Blood Pressure Screening (Age 18 and older)	100%	50%	100%	50%	100%	50%	100%	50%
	Chest X-Ray/EKG (once per year)	100%	50%	100%	50%	100%	50%	100%	50%
	Cholesterol Screening (Adults certain ages or at higher risk)	100%	50%	100%	50%	100%	50%	100%	50%
47, 68, 88	*Colorectal Cancer Screening /Colonoscopy .(Adults 45 years old and older, once every 5 years.) (A polyp removal during a colonoscopy screening, is considered an integral part of the preventive service.) Cologuard is covered.*	100%	50%	100%	50%	100%	50%	100%	50%
Amd4	*Anesthesia with Colonoscopy*	100%	50%	100%	50%	100%	50%	100%	50%
	Depression Screening	100%	50%	100%	50%	100%	50%	100%	50%
	Diabetes (Type 2) Screening (Adults with high blood pressure)	100%	50%	100%	50%	100%	50%	100%	50%
	Diet Counseling (Adults at higher risk for chronic disease)	100%	50%	100%	50%	100%	50%	100%	50%
	Hepatitis B Screening (For people at high risk)	100%	50%	100%	50%	100%	50%	100%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Hepatitis C Screening (Adults at increased risk, and one time for everyone born 1945 – 1965.)	100%	50%	100%	50%	100%	50%	100%	50%
	HIV Screening	100%	50%	100%	50%	100%	50%	100%	50%
	Routine Labs	100%	50%	100%	50%	100%	50%	100%	50%
	Lung Cancer Screening (Adults ages 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years)	100%	50%	100%	50%	100%	50%	100%	50%
	Obesity Screening & Counseling	100%	50%	100%	50%	100%	50%	100%	50%
	Prostate-Specific Antigen (PSA)	100%	50%	100%	50%	100%	50%	100%	50%
	Sexually transmitted Infection (STI) prevention counseling	100%	50%	100%	50%	100%	50%	100%	50%
	Syphilis Screening	100%	50%	100%	50%	100%	50%	100%	50%
	Tobacco Use Screening	100%	50%	100%	50%	100%	50%	100%	50%
		Immunization Vaccine for Adults Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"), including flu shots.							
	Diphtheria	100%	50%	100%	50%	100%	50%	100%	50%
	Hepatitis A	100%	50%	100%	50%	100%	50%	100%	50%
	Hepatitis B	100%	50%	100%	50%	100%	50%	100%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Herpes Zoster (Shingles Shot. Age 60 and older)	100%	50%	100%	50%	100%	50%	100%	50%
	Human Papillomavirus (HPV)	100%	50%	100%	50%	100%	50%	100%	50%
	Influenza (Flu Shot)	100%	50%	100%	50%	100%	50%	100%	50%
	Measles	100%	50%	100%	50%	100%	50%	100%	50%
	Meningococcal	100%	50%	100%	50%	100%	50%	100%	50%
	Mumps	100%	50%	100%	50%	100%	50%	100%	50%
	Pertussis	100%	50%	100%	50%	100%	50%	100%	50%
	Pneumococcal	100%	50%	100%	50%	100%	50%	100%	50%
	Rubella	100%	50%	100%	50%	100%	50%	100%	50%
	Tetanus	100%	50%	100%	50%	100%	50%	100%	50%
	Varicella (Chickenpox)	100%	50%	100%	50%	100%	50%	100%	50%
		Routine Preventive Services for Women, Including Pregnant Women (Age 18 and older)							
	Well Woman Visits	100%	50%	100%	50%	100%	50%	100%	50%
	Anemia Screening (On a routine basis)	100%	50%	100%	50%	100%	50%	100%	50%
	Breastfeeding Comprehensive Support & Counseling	100%	50%	100%	50%	100%	50%	100%	50%
	Breast Pump (limited to one per pregnancy)	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Contraception (Contraceptive methods must be FDA approved. Abortifacient drugs are not covered)	100%	50%	100%	50%	100%	50%	100%	50%
	Folic Acid (Supplements for women who may become pregnant)	100%	50%	100%	50%	100%	50%	100%	50%
	Gestational Diabetes Screening (Women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes)	100%	50%	100%	50%	100%	50%	100%	50%
	Gonorrhea Screening (Women at high risk)	100%	50%	100%	50%	100%	50%	100%	50%
	Hepatitis B Screening (Pregnant women at their first prenatal visit)	100%	50%	100%	50%	100%	50%	100%	50%
	Rh Incompatibility (Pregnant women and follow-up testing for women at higher risk)	100%	50%	100%	50%	100%	50%	100%	50%
	Syphilis Screening	100%	50%	100%	50%	100%	50%	100%	50%
	Expanded Tobacco Intervention And Counseling (Pregnant tobacco users)	100%	50%	100%	50%	100%	50%	100%	50%
	Urinary Tract or other infection Screening	100%	50%	100%	50%	100%	50%	100%	50%

Page	4 Plan Design Options	Consumer Driven Health Plan (with H.S.A.)		Comprehensive Health Plan		Premium Health Plan		Premium Plus Plan	
	Breast Cancer Genetic Test Counseling (BRCA) (Women at higher risk)	100%	50%	100%	50%	100%	50%	100%	50%
	Breast Cancer Mammography Screening (Every 1 to 2 years for women over 40)	100%	50%	100%	50%	100%	50%	100%	50%
	Breast Cancer Chemoprevention Counseling (Women at higher risk)	100%	50%	100%	50%	100%	50%	100%	50%
	Cervical Cancer Screening (For sexually active women)	100%	50%	100%	50%	100%	50%	100%	50%
	Chlamydia Infection Screening (Women and younger women at higher risk)	100%	50%	100%	50%	100%	50%	100%	50%
	Domestic and Interpersonal Violence Screening & Counseling (All women)	100%	50%	100%	50%	100%	50%	100%	50%
	HIV Screening & Counseling (For sexually active women)	100%	50%	100%	50%	100%	50%	100%	50%
	Tobacco Use Screening and Interventions	100%	50%	100%	50%	100%	50%	100%	50%

		Children Preventive							
	Well Child Exam	100%	50%	100%	50%	100%	50%	100%	50%
	Alcohol & Drug Use Assessments (For Adolescents)	100%	50%	100%	50%	100%	50%	100%	50%
	Autism Screening (Children at 18 and 24 months)	100%	50%	100%	50%	100%	50%	100%	50%
	Behavioral Assessments (Ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)	100%	50%	100%	50%	100%	50%	100%	50%
	Blood Pressure Screening (Ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)	100%	50%	100%	50%	100%	50%	100%	50%
	Cervical Dysplasia Screening (For sexually active females)	100%	50%	100%	50%	100%	50%	100%	50%
	Depression Screening (For Adolescents)	100%	50%	100%	50%	100%	50%	100%	50%
	Developmental Screening (For children under age 3	100%	50%	100%	50%	100%	50%	100%	50%
	Dyslipidemia screening (children at higher risk of lipid disorders ages 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)	100%	50%	100%	50%	100%	50%	100%	50%

	Fluoride Chemoprevention Supplements (For children without fluoride in their water source)	100%	50%	100%	50%	100%	50%	100%	50%
	Gonorrhea Prevention Medication (For the eyes of all newborns)	100%	50%	100%	50%	100%	50%	100%	50%
	Hearing Screening (For newborns)	100%	50%	100%	50%	100%	50%	100%	50%
	Height, Weight, and Body Mass Index (BMI) Measurements (Children ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)	100%	50%	100%	50%	100%	50%	100%	50%
	Hemoglobinopathies or Sickly Cell Screening (For newborns)	100%	50%	100%	50%	100%	50%	100%	50%
	Hepatitis B Screening (Adolescents at higher risk)	100%	50%	100%	50%	100%	50%	100%	50%
	HIV Screening (Adolescents at higher risk)	100%	50%	100%	50%	100%	50%	100%	50%
	Hypothyroidism Screening (For newborns)	100%	50%	100%	50%	100%	50%	100%	50%
	Iron Supplements (Children age 6 to 12 months at risk for anemia)	100%	50%	100%	50%	100%	50%	100%	50%
	Lead Screening (Children at risk of exposure)	100%	50%	100%	50%	100%	50%	100%	50%

	Medical History (For all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)	100%	50%	100%	50%	100%	50%	100%	50%
	Obesity Screening and Counseling	100%	50%	100%	50%	100%	50%	100%	50%
	Oral Health Risk Assessment (Ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)	100%	50%	100%	50%	100%	50%	100%	50%
	Phenylketonuria (PKI) Screening (For newborns)	100%	50%	100%	50%	100%	50%	100%	50%
	Sexually Transmitted infection (STI) Prevention Counseling & Screening (Adolescents at higher risk)	100%	50%	100%	50%	100%	50%	100%	50%
	Tuberculin testing (Children at higher risk of tuberculin ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)	100%	50%	100%	50%	100%	50%	100%	50%
5/14 SMM	*Vision Screening (For all children. Must be billed with a preventive visit)*	100%	50%	100%	50%	100%	50%	100%	50%

		Immunization Vaccines for Children (For children from birth to age 18 – doses, recommended ages, and recommended populations vary.) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"), including flu shots.							
	Diphtheria, Tetanus, Pertussis (Whooping Cough)	100%	50%	100%	50%	100%	50%	100%	50%
	Haemophilus Influenza Type B	100%	50%	100%	50%	100%	50%	100%	50%
	Hepatitis A	100%	50%	100%	50%	100%	50%	100%	50%
	Hepatitis B	100%	50%	100%	50%	100%	50%	100%	50%
	Human Papillomavirus (PVU)	100%	50%	100%	50%	100%	50%	100%	50%
	Inactivated Poliovirus	100%	50%	100%	50%	100%	50%	100%	50%
	Influenza (Flu Shot)	100%	50%	100%	50%	100%	50%	100%	50%
	Measles	100%	50%	100%	50%	100%	50%	100%	50%
	Meningococcal	100%	50%	100%	50%	100%	50%	100%	50%
	Pneumococcal	100%	50%	100%	50%	100%	50%	100%	50%
	Rotavirus	100%	50%	100%	50%	100%	50%	100%	50%
	Varicella (Chickenpox)	100%	50%	100%	50%	100%	50%	100%	50%
	Sexual Dysfunction Services	**Not Covered**							
	Skilled Nursing	Skilled Nursing Facility or Subacute Care Facility is payable up to 120-day maximum per calendar year.							
	SNF	80%	Not Covered	90%	Not Covered	90%	Not Covered	90%	Not Covered
	Sub-Acute Care Facility	80%	Not Covered	90%	Not Covered	90%	Not Covered	90%	Not Covered
	Sleep Study	80%	50%	90%	50%	90%	50%	90%	50%
	Smoking Cessation	OTC Tobacco cessation products are payable at 100%. See Mental Health for additional benefits.							

	Acupuncture	80%	50%	90%	50%	90%	50%	90%	50%
	Low Level Laser Treatment	80%	50%	90%	50%	90%	50%	90%	50%
	Sterilization	Reversal is not covered.							
66	*Vasectomy*	100%	50%	100%	50%	100%	50%	100%	50%
	Tubal ligation	100%	50%	100%	50%	100%	50%	100%	50%
	Substance Abuse	Contact **Cigna Behavioral Health at (877) 622-4327.** Per Consultant: Although Outpatient Behavioral Health does not require pre-certification, we still want to steer people to **Cigna Behavioral Health** for all EAP/Behavioral Health issues. We want them to use their 8 free EAP visits before seeking outpatient care. And, we prefer to have the EAP/BH provider direct them to the best provider for their specific condition. Members may also use these services for counseling for Tobacco addiction. NOTE: BENEFITS ARE PAYABLE ONLY FOR SERVICES OF BEHAVIORAL HEALTH CARE PRACTITIONERS – A psychiatrist, psychologist, or a mental health counselor or social worker who has a Master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling or child of the patient. EFF 1/1/15 NOTE: RESIDENTIAL TREATMENT PROGRAM/FACILITY/CARE – is a non-acute hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan a facility must be licensed as a residential treatment facility and contracted with the PPO Network. Licensure requirements for this residential level of care may vary by state.							
	Inpatient	80%	50%	90%	50%	90%	50%	90%	50%
PM	*Partial Hospitalization/ Day Treatment*	80%	50%	90%	50%	90%	50%	90%	50%
Amd1	*Residential Treatment Facility*	80%	Not Covered	90%	Not Covered	90%	Not Covered	90%	Not Covered
	Outpatient	80%	50%	100% $25 copay	50%	100% $20 copay	50%	100% $10 copay	50%

Amd7	**Surgery**	Effective 5/1/16, ancillary services received from an out-of-network provider (outside the patient's choice) in connection with a visit to, surgery or serviced performed by an in-network provider will process with in-network benefit levels with the out-of-network allowance. **EFFECTIVE 1/1/2022 NO SURPRISE ACT** - FOR SERVICES RENDERED IN AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER, NON-PARTICIPATING PROVIDERS SUCH AS ANESTHESIA, ANESTHESIOLOGIST, PATHOLOGY, RADIOLOGY, NEONATOLOGY, DIAGNOSTIC SERVICES, ASSITANT SURGEON, HOSPITALIST, AND INTENSIVIST SERVICES. THESE NON-PARTICIPATING PROVIDERS CANNOT BALANCE BILL AND MAY NOT ASK PATIENTS TO GIVE UP PROTECTIONS NOT TO BE BALANCE BILLED. These Services will pay at the IN-Network rate and payments will be **processed using QPA (Qualified Payment Amount).**								
	Inpatient	80%	50%	90%	50%	90%	50%	90%	50%
	Outpatient	80%	50%	90%	50%	90%	50%	90%	50%
	Office	80%	50%	90%	50%	90%	50%	90%	50%
	Surgeon	80%	50%	90%	50%	90%	50%	90%	50%
	Assistant Surgeon	Physicians who act as an Assistant Surgeon will be reimbursed for Medically Necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. All other health care practitioners who act as an Assistant Surgeon (e.g., physician assistant, nurse practitioner) will be reimbursed for Medically Necessary services to a maximum of 15% of the eligible expenses payable to the primary surgeon. Certified Surgical Assistants (as defined by the Fund) are not payable.							
	ASC	80%	50%	90%	50%	90%	50%	90%	50%
	Anesthesia/CRNA	80%	50%	90%	50%	90%	50%	90%	50%
	Pre-Admission Testing	80%	50%	90%	50%	90%	50%	90%	50%
26	*Endoscopy*	80%	50%	90%	50%	90%	50%	90%	50%
26, 48, 68, 88	*Colonoscopy High Risk Under age 50*	A polyp removal during a colonoscopy screening, is considered an integral part of the preventive service.							
		80%	50%	90%	50%	90%	50%	90%	50%
	Lasik	Not Covered		Not Covered		Not Covered		Not Covered	
	Therapy								
	Physical	80%	50%	90%	50%	90%	50%	90%	50%
	Occupational	80%	50%	90%	50%	90%	50%	90%	50%

PM	*Self Care Management Training*	80%	50%	90%	50%	90%	50%	90%	50%
	Speech	Speech Therapy is covered to restore normal speech or to correct dysphagia or swallowing defect and disorder lost due to illness, injury or surgical procedure. Functional purposes (e.g., speech impediment, stuttering, lisping, tongue thrust, stammering, conditions of psychoneurotic origin or childhood developmental speech delays and disorders are NOT covered.							
		80%	50%	90%	50%	90%	50%	90%	50%
	Radiation	80%	50%	90%	50%	90%	50%	90%	50%
	Chemotherapy	80%	50%	90%	50%	90%	50%	90%	50%
	Cardiac Rehab	80%	50%	90%	50%	90%	50%	90%	50%
	Pulmonary Rehab	80%	50%	90%	50%	90%	50%	90%	50%
	Inpatient Rehabilitation Therapy	80%	Not Covered	90%	Not Covered	90%	Not Covered	90%	Not Covered
	External Therapy (Nutritional Therapy)	Covered when formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and ALL the following criteria are met. Without individual would be unable to maintain an appropriate weight by dietary adjustment/or supplements and the individual has one of the following conditions an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel, disease of the small bowel that impairs absorption of an oral diet, a central nervous or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.							
	Nutrition	80%	50%	90%	50%	90%	50%	90%	50%
	Intravenous (Iron Therapy)	80%	50%	90%	50%	90%	50%	90%	50%
	Vision Therapy	Not Covered		Not Covered		Not Covered		Not Covered	
	TMJ	See benefit under Dental Oral, Craniofacial, and TMJ Services							

	Transplants	*****See MSR Notes for the procedures and network/negotiated discounts on Transplants ***** **Please email Shared_StopLossClaims@benesys.com to provide notification of any upcoming transplant cases.** Heart, Kidney, Cornea, Bone Marrow, Lung, Liver, Heart/Lung, Pancreas and Kidney/Pancreas, approved FDA drugs and Medically Necessary equipment. No coverage for expenses incurred by a person who donates an organ or tissue, unless the person who receives the donated organ/tissue is the person covered by the fund. Donor expenses are payable to a maximum of $20,000 per person per transplant.								
	Organ	80%	50%	90%	50%	90%	50%	90%	50%
	Donor	80%	50%	90%	50%	90%	50%	90%	50%
	To be Donor	80%	50%	90%	50%	90%	50%	90%	50%
	Cadaver Donor	80%	50%	90%	50%	90%	50%	90%	50%
	Live Donor/To be Live Donor	80%	50%	90%	50%	90%	50%	90%	50%
Amd6, 72	**Out-of-Network Transplant Maximums**	Heart: $110,000 including a max of $20,000 for Physicians services Lung: $155,000 including a max of $20,000 for Physicians services Bone Marrow: $130,000 including a max of $20,000 for Physician services Liver: $130,000 including a max of $20,000 for Physician services Heart/Lung: $150,000 including a max of $20,000 for Physician services Pancreas: $70,000 including a max of $20,000 for Physician services Kidney: $55,000 including a max of $20,000 for the Physician services Pancreas $95,000 including a max of $20,000 for the Physician services							
	Transplant Related Travel	$10,000 per transplant for related travel expenses, including transportation, lodging for a patient and one family member or companion. Reimbursement is available for round trip "coach" airfare and up to a max of $200 per day for lodging (pre-op work up, transplant operation and post-transplant treatment phase) Receipts are required. Still follow plan outline 80%, 50% or 90%, 50%.							
	Vision	Vision Claims with Medical Diagnosis will be paid under medical and processed with Cigna discount. Routine vision exam claims with a vision diagnosis can also be sent to Cigna for discount if the provider is a PPO provider under Cigna. If the provider is non par, everything is paid from the vision plan.							

General Exclusions and Limitations	
Adoption Counseling	Expenses for services related to adoption counseling
Alternate Therapy Expenses	Expenses for hypnosis, hypnotherapy and/or biofeedback
Autopsy	Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
Educational Services	Expenses for educational services, supplies or equipment, including, but not limited to private or public school expenses, computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, special education, etc., even if they are required because of an injury, illness or disability of a Covered Individual
Employer-Provided Services	Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by your Employer
Expenses Exceeding Maximum Plan Benefits	Expenses that exceed any Plan benefit limitation, or Annual Maximum Plan Benefits, as described in the Schedule of Medical Benefits chapter of this document
Expenses Exceeding Allowed Charges	Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions chapter of this document.
Expenses for Which a Third Party Is Responsible	Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. Expenses for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Liability in the chapter on Coordination of Benefits in this document for an explanation of the circumstances under which the Fund will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
Expenses Incurred Before or After Coverage	Expenses for services rendered or supplies provided before the patient became covered under the medical, dental and vision plans; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
Experimental and/or Investigational Services	Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
Gene Therapy	Expenses for or related to gene therapy (a technique that uses human genes to treat or prevent disease in humans which can include introducing human DNA genetic material into an individual to treat or prevent a disease or correct a faulty/missing gene
Halfway House and/or Wilderness Therapy Program	Expenses for halfway house, wilderness therapy program, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care, group home

Illegal Act	To the extent legally permitted including but not limited to the source of injury guidelines, expenses incurred by any Covered Individual for injuries and/or illness resulting from or sustained as a result of, or in any way connected to, the commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator or its designee determines in its sole discretion, including but not limited to any misdemeanor or felony behavior; an illegal act shall be presumed if any action involves force or violence or the threat of force or violence by the Covered Individual or to another person or an act in which a firearm, explosive, weapon or instrument likely to or capable of causing physical harm or death is used by the Covered Individual. The Plan Administrator's or its designee's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
Learning Disorders Expenses	Expenses for tests to determine the presence of or degree of a person's attention deficit disorder, dyslexia or learning disorder
	Expenses for services related to attention deficit disorders (without hyperactivity).
Leaving a Hospital Contrary to Medical Advice	Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission
Medically Unnecessary Services	Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.
Military Service-Related Injury/Illness	If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
Modifications of Homes or Vehicles	Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc.
No-Cost Services	Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
No Physician Prescription	Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician or Health Care Practitioner.
Non-Emergency Travel and Related Expenses	Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual, unless those travel expenses are related to a plan approved transplant as outlined under Transplants in the Schedule of Medical Benefits.
Personal Comfort Items	Expenses for patient convenience, comfort, hygiene or beautification, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, DVD/Compact Disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
Physical Examinations, Tests for Employment, School	Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party. See however the wellness benefits payable under Preventive Services Programs in the Wellness row of the Schedule of Medical Benefits

Private Room in a Hospital or Health Care Facility	The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee
Medical Students or Interns	Expenses for the services of a medical student or intern
Non-Routine Services and Supplies Associated with Clinical Trial	(1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
Services Provided Outside the United States	Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency (as defined in the Definitions chapter of this document).
Services related to a Court Order	Expenses for or related to examinations, reports or appearances in connection with legal proceedings or accommodations pursuant to a court order, whether or not a sickness or accidental injury is involved, **unless** the services requested are determined by the Plan Administrator or its designee to be Medically Necessary and are a covered benefit under the Plan.
Specifically Identified Providers and/or Facilities	Regarding implementing a reasonable medical management technique with respect to the frequency, method, treatment or setting for care, all non-emergency services, supplies or other expenses for consultation, care or treatment of any injury, sickness, illness, disease or preventive services at or by the following providers and/or facilities (notwithstanding any other provision or term or condition in the Plan) are not covered: Cancer Treatment Centers of America (CTCA) and related providers and affiliates.
Stand-By Physicians or Health Care Practitioners	Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis
State Surcharges	Any surcharges a Participant incurs as a result of state laws (e.g., New York Health Care Reform Act, Massachusetts Uncompensated Care Pool Surcharge).
Telephone Calls	Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation: Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members
Travel Contrary to Medical Advice	Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual
War or Similar Event	Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law
Workers Compensation	All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if you or your covered Dependent were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES	
Alternative/Complementary Health Care Services Exclusions	1. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron. 2. Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner. 3. Expenses for naturopathic, naprapathic and/or homeopathic treatments/supplies.
Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions	1. Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions chapter of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners. 2. Expenses for **replacement of lost, missing, or stolen**, **duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment, except that replacement or repair of a prosthetic device is payable once in a five-year period provided prior authorization has been obtained from the Utilization Management Company. 3. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment. 4. Expenses for occupational therapy **(orthotic) supplies and devices** needed to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing, shower bench, and raised toilet seat. 5. Expenses for **nondurable supplies,** except as payable under Nondurable Supplies in the Schedule of Medical Benefits. 6. Corrective shoes or supportive devices for the feet including orthotics unless they are an integral part of a lower body brace.
Cosmetic Services Exclusions	Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. Plan Participants should use the Plan's Precertification procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery
Custodial Care Exclusions	1. Expenses for Custodial Care as defined in the Definitions chapter of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, personal care, sitter/companion service, assisted living arrangements, memory care, or senior care facility/program. 2. Services required to be performed by Physicians, Nurses or other Skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are Medically Necessary

Dental Services Exclusions	1. Expenses for **Dental Prosthetics or Dental services or supplies** of any kind, even if they are necessary because of symptoms, illness or injury affecting the mouth or another part of the body, unless certain conditions noted below apply. See also the Dental benefits noted in the Dental Plan chapter in this document available to Participants enrolled in the Premium Health Plan, Premium Plus Plan and the Comprehensive Health Plan. Expenses for Dental Prosthetics and Dental services may be covered under the Medical Plan only if they are incurred: a. For the repair or replacement of Accidental Injury to the Teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Fund, an accident does not include any injury caused by biting or chewing. b. As a result of a congenital malformation/defect. See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits for additional information. For assistance in determining if certain dental services are payable under the Medical Plan contact the Administrative Office. 2. Expenses for the medical or surgical **treatment of Temporomandibular Joint (TMJ) Dysfunction or Syndrome, unless** approved via the preauthorization process described in the Utilization Management chapter of this document. 3. Expenses for upper and lower jaw augmentation or reductions procedures (**Orthognathic services/surgery)** for treatment of Prognathism, Retrognathism and other reasons determined by the Plan Administrator or its designee to be cosmetic and not Medically Necessary. 4. Expenses for **oral surgery** for gingivectomies, treatment of dental abscesses, extraction of boney impacted teeth, and root canal (endodontic) therapy

Drugs, Medicines and Nutrition Exclusions	1. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e., are used "off-label"); or are Experimental and/or Investigational as defined in the Definitions chapter of this document. The Board of Trustees may exercise its discretion on appeal (by the participant) to waive the off-label exclusion where the Board finds upon clear and convincing evidence that (1) the prescribed pharmaceutical shows demonstrable benefit to the participant, (2) the appropriate utilization manager supports the off-label use of the pharmaceutical and (3) determines that the cost-saving benefit to the off-label use exceeds expected expenses in the absence of such use. 2. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin and certain over-the- counter(OTC) medication prescribed by a Physician or Health Care Practitioner, or drugs covered without cost-sharing in accordance with Health Reform regulations. 3. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs, minerals or medical foods for persons with inherited metabolic disorders (whether they can be purchased over-the- counter or require a prescription), except foods and nutritional supplements provided during a covered Hospitalization and benefits for Enteral Therapy as described in the Schedule of Medical Benefits. 4. Naturopathic, naprapathic or homeopathic substances. 5. Drugs, medicines or devices for: • Cosmetic drugs such as Renova and depigmenting agents; • Desi drugs (drugs determined by the Food and Drug Administration to lack effectiveness); • Non-prescription male contraceptives; • Fertility and/or infertility; • Dental products such as fluoride preparations and products for periodontal disease, except when prescribed by a Physician or Health Care Practitioner, or as covered without cost-sharing in accordance with Health Reform regulations; • Hair removal or hair growth products (i.e., Propecia, Rogaine, Minoxidil, Vaniqa); • Vitamins including prenatal vitamins, except when prescribed by a Physician or Health Care Practitioner, or as covered without cost-sharing in accordance with Health Reform regulations; • Vitamin A derivatives (tretinoin/retinoids) for dermatologic use (i.e., Retin A, Renova) for patients age 26 and older. Weight control or anorexiants, except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy. • Drug treatment of female hypoactive sexual desire disorder (HSDD) (e.g. prescription drugs such as Addyi). 6. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal law. 7. Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility. 8. Vaccinations, immunizations, inoculations or preventative injections, except those provided under Preventive Services Programs for children and/or adults (see the Wellness row of the Schedule of Medical Benefits), and those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin

Durable Medical Equipment Exclusions	***See the Exclusions related to Corrective Appliances and Durable Medical Equipment***
Fertility and Infertility Services Exclusions	Expenses for the diagnosis of and medical or surgical treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures
Foot/Hand Care Exclusions	Expenses for routine foot care, (including but not limited to trimming of toenails, removal of callouses, preventive care with assessment of pulses, skin condition and sensation) or treatment of chronic conditions of the foot such as weak or fallen arches, flat or pronated foot metatarsalgia or foot strain, or hand care including manicure and skin conditioning. Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet
Genetic Testing and Counseling Exclusions	1. **Genetic Testing:** The following expenses for genetic tests are not covered, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics. (Certain genetic tests are covered as listed in the Genetic Testing row in the Schedule of Medical Benefits.) Genetic services that are **not covered** include: a. **Pre-parental genetic testing** (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children); b. Expenses for **Pre-implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization; c. No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the treatment of a covered plan participant; d. **Home genetic testing kits/services** are not covered. See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan. Plan Participants can contact the Medical Plan Claims Administrator for assistance in determining if a proposed Genetic Test will be covered or excluded. 2. **Genetic Counseling:** Expenses for genetic counseling are not covered, unless these three conditions are met: is ordered by a Physician, performed by a qualified genetic counselor and performed in conjunction with a genetic test that is payable by this Plan
Hair Exclusions	Expenses for hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or for hair replacement devices including, but not limited to, wigs, toupees, cranial hair prosthesis, and/or hairpieces; or hair analysis
Hearing Care Exclusions	Special education and associated costs in conjunction with sign language education for a patient or family members

Home Health Care Exclusions	1. Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies. 2. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician. 3. Expenses for a homemaker, custodial care, childcare, adult care, caregiver or personal care attendant, except as provided under the Plan's Hospice coverage.
Maternity/Family Planning Exclusions	1. **Adoption expenses or birth expenses of an adopted child(ren)**. 2. Expenses related to **non-prescription male contraceptive drugs and devices** such as condoms. 3. **Termination of Pregnancy:** Expenses for elective termination of pregnancy (abortion) unless attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or where complications arise from an abortion. 4. **Home Delivery:** Expenses for pre-planned home delivery. 5. Expenses related to **ultrasounds and delivery expenses associated with a pregnant Dependent Child,** except that complications of the pregnant Dependent Child will be payable. See the definition of "Complications" in the Definitions chapter. See the Maternity row in the Schedule of Medical Benefits. 6. Expenses for **childbirth education and Lamaze classes**. **7. Expenses related to the surrogate mother's pregnancy, delivery and complications.** 8. Expenses related to cryostorage of umbilical cord blood or other tissue or organs
Nursing Care Exclusions	Expenses for services of private duty nurses
Prophylactic Surgery or Treatment Exclusions	Expenses for prophylactic medical, surgical and prescription drug treatment is generally not a payable benefit. Prophylactic/Preventive Services will be covered if they meet the Preventive Services Program described in the Wellness row of the Schedule of Medical Benefits (such as preventive immunizations). The following prophylactic/preventive services could be covered if precertified as medically necessary by the Utilization Management firm: prophylactic mastectomy (removal of breast), prophylactic oophorectomy (removal of ovary) or prophylactic hysterectomy (removal of uterus). While precertification is not a guarantee of payment of benefits, Plan Participants should use the Plan's Precertification procedure to determine if a proposed service is considered Prophylactic

Rehabilitation Therapy Exclusions (Inpatient or Outpatient)	1. Expenses for educational, job training, vocational rehabilitation, and/or special education such as sign language, etc. 2. Expenses for massage therapy, rolfing and related services. 3. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and services. 4. Expenses for Maintenance Rehabilitation as defined in the Definitions chapter of this document. 5. Expenses for speech therapy unless required to restore to function speech loss or impediments due to illness or injury. 6. Expenses for treatment of delays in childhood speech development unless as a direct result of an injury, surgery or result of a covered treatment. **7.** Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired) including treatment of delays in childhood speech and physical development, even if the delay in development is a direct result of an injury, surgery or as a result of a treatment that is the type that is covered by this Plan.
Sexual Dysfunction Services Exclusions	1. **Treatment of Sexual Dysfunction**: Expenses for the diagnosis or surgical treatment of sexual dysfunction and any complications thereof. Note that medication to treat erectile dysfunction is payable under the Outpatient Prescription Drug benefit in the Schedule of Medical Benefits chapter. 2. **Sex Change Counseling, Therapy and Surgery:** Expenses for medical, surgical or prescription drug treatment related to transsexual (sex change) procedures, or the preparation for such procedures, or any complications thereof
Transplant (Organ and Tissue) Exclusions	1. Expenses for human organ and/or tissue transplants that are not mentioned as covered (under Transplantation in the Schedule of Medical Benefits) or are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post operative services and drugs or medicines, and all complications thereof. 2. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves. 3. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except heart valves and kidney dialysis. 4. For plan participants who serve as a donor, donor expenses are not payable by this Plan unless the person who receives the donated organ/tissue is the person covered by this Plan.
Vision Care Exclusions	1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In Situ Keratomileusis (LASIK). 2. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except as provided by the Vision Plan (and described in a separate chapter of this document). 3. Vision therapy (orthoptics) and supplies. 4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision. 5. Expenses related to the treatment of contact lens intolerance

Weight Management and Physical Fitness Exclusions	1. Expenses for medical or surgical treatment of obesity, including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, skin reduction procedures/treatment, and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying health condition. This exclusion does not apply to the extent that it constitutes screening and counseling for obesity or otherwise qualifies under the Preventive Services Program category (see the Wellness row of the Schedule of Medical Benefits). 2. Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight. 3. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services, exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers
Trustees or their insurance carriers may apply additional exclusions. The Trustees reserve the right to modify these exclusions as they, in their sole discretion deem appropriate. If you have any questions about covered services, contact the Plan Administrator prior to incurring the expense.	