Silver

2024 Schedule of Medical Benefits

If the service is not listed on this Schedule of Benefits, it is not covered.

PPO Provider Network:
PHCS Practitioner & Ancillary
Out-of-Network Providers:
Not Covered
Facilities (Reference Based Pricing):
**140% of Medicare Allowable Amount

***D - PreCertification**

***Precertification is required. Failure to obtain preauthorization will result in a denial of benefits.**
***Preauthorization is required for any service or procedure over $1,000.**
All services must be deemed medically necessary.
Coverage begins the 1st of the month following 60 days of employment. Coverage ends the last day of the month in which termination occurred.
Preventive Service Benefits are based on a Plan Year. No benefits for preventive services performed at a hospital.
Out of Country Care is not covered.
Note: Any non-allowed or not covered amounts or services are the responsibility of the patient and not included in the Out-of-Pocket Maximum.
Dependents covered to age 26 regardless of student or marital status.
Timely Filing: Medical Claims must be filed within 12 months from the date the service incurred.
Rural Area is defined as 50 miles. If preventive services are not available within 50 miles of your residence, the provider will be paid in network.
Any person that is eligible for Medicare is not eligible for this plan.
If the service is not listed on the Schedule of Benefits, it is not covered.
Maternity - Professional Services: If billed as a Global OB/Maternity Care, it will include physician services for uncomplicated, maternity related care during pregnancy, delivery and postpartum. Many services are bundled and billed by the provider as a package. Any service billed separately from the Global OB Package will apply to the corresponding benefit; i.e., additional office visits will require an office visit copay; laboratory testing billed separately will require a laboratory copay. Members may verify with the physician's office which services are included in billing for Global Maternity Care.

	Lifetime Maximum: None	Network Providers	Out-of-Network Providers	Benefit Limits
	Annual Deductibles (does not include co-pays)	Individual: $0 Family: $0	None	**Limits are per person per Plan Year.**
	Annual Out of Pocket Maximums (Includes medical deductible, medical co-pays and medical co-insurance)	Individual: $5,000 Family: $10,000	None	
	Office Visits - Primary Care (exams or consultations)	$15 Copay, then Plan pays 100% of the PPO Amount	No Benefit	Limited to 10 visits per Plan Year. Limit is not combined with Specialist visits.
	Office Visits - Specialist (exams or consultations)	$25 Copay, then Plan pays 100% of the PPO Amount	No Benefit	Limited to 10 visits per Plan Year. Limit is combined with Outpatient Chemical Dependency and Mental Health.
*D	*Chemical Dependency - Inpatient	$350 Copay per adminssion, then Plan pays 100% of Allowed Amount (**Plan payment is based on 140% of Medicare Allowable Amount)		Benefits are limited to 7 days per Plan Year. Limit combined with Inpatient Hospitalization, Mental Health - Inpatient, and Maternity - Facility Childbirth & Delivery. **Patient may be balance billed if the provider does not accept 140% of Medicare Allowable Payment
	Chemical Dependency - Outpatient In-Office	$25 Copay per day, then Plan pays 100% of the PPO Amount	No Benefit	Benefits are limited to 10 days per Plan Year. Limit combined with Specialist Visits and Outpatient Mental Health.
*D	*Chemical Dependency - Outpatient Facility	$350 Copay, then Plan pays 100% of Allowed Amount (**Plan payment is based on 140% of Medicare Allowable Amount)		Benefit is Limited to 2 admission per Plan Year. Limit combined with Oupatient Surgery - Facilty and Mental Health - Outpatient Facility. **Patient may be balance billed if the provider does not accept 140% of Medicare Allowable Payment
	Diagnostic Services - Basic X-Rays In-Office (related to office visit, LabCorp, etc)	$50 Copay per image, then Plan pays 100% of PPO Amount	No Benefit	Co-pay is per x-ray billed. Limit 3 per Plan Year. Limit is combined with Basic Labs In-Office. **No Benefits for services provided in a hospital.**
	Diagnostic Services - Basic Labs In-Office (related to office visit, LabCorp, etc)	$50 Copay per panel, then Plan pays 100% of PPO Amount	No Benefit	Co-pay is per panel billed. Limit 3 per Plan Year. Limit is combined with Basic X-rays In-Office. **No Benefits for services provided in a hospital.**
*D	Diagnostic Services - Major In-Office (CT, MRI, MRA, PET)	$350 Copay per image, then Plan pays 100% of PPO Amount	No Benefit	Co-pay is per image billed. Limit 2 per Plan Year. **No Benefits for services provided in a hospital.**
	Emergency Room - Facility	$350 Copay, then Plan pays 100% of Allowed Amount (**Plan payment is based on 140% of Medicare Allowable Amount)		Limited to 1 visit per Plan Year. Coverage limited to emergent services only. **Patient may be balance billed if the provider does not accept 140% of Medicare Allowable Payment.
	Emergency Room - All services other than facility charges			
*D	Home Health Care	$25 Copay, then Plan pays 100% of the PPO Amount	No Benefit	Limited to 10 visits per Plan Year.
*D	Hospital - Inpatient Services	$350 Copay per adminssion, then Plan pays 100% of Allowed Amount (**Plan payment is based on 140% of Medicare Allowable Amount)		Limited to 7 days per Plan Year. Combined with Hospital - Inpatient Services - Surgery. Includes Mental Health and Substance Abuse. **Patient may be balance billed if the provider does not accept 140% of Medicare Allowable Payment.

*D	Hospital - Inpatient Surgery	$350 Copay per surgery, then Plan pays 100% of Allowed Amount (**Plan payment is based on 140% of Medicare Allowable Amount)		Limited to 3 Surgeries per Plan Year. Each surgery is considered 1 day in hospital. Combined with Hospital - Inpatient Services Includes Mental Health & Substance Abuse. **Patient may be balance billed if the provider does not accept 140% of Medicare Allowable Payment.
	Maternity - Facility Childbirth & Delivery	$350 Copay, then Plan pays 100% of the Allowed Amount (**Plan payment is based on 140% of the Allowable Amount)		**Patient may be balance billed if the provider does not accept 140% of the Medicare Allowable Amount
	Maternity - Professional Services	$350 Copay, then Plan pays 100% of the PPO Amount	No Benefit	Global OB/Maternity Care: See "Maternity - Professional Services" on Page 1.
*D	*Mental Health - Inpatient	$350 Copay per adminssion, then Plan pays 100% of Allowed Amount (**Plan payment is based on 140% of Medicare Allowable Amount)		Benefits are limited to 7 days per Plan Year. Limit combined with Inpatient Hospitalization and Chemical Dependency. **Patient may be balance billed if the provider does not accept 140% of Medicare Allowable Payment
	Mental Health - Outpatient In-Office	$25 Copay, then Plan pays 100% of the PPO Amount	No Benefit	Benefits are limited to 10 days per Plan Year. Limit combined with Specialists Visits, Outpatient Chemical Dependency and Mental Health.
*D	*Mental Health - Outpatient Facility	$350 Copay, then Plan pays 100% of Allowed Amount (**Plan payment is based on 140% of Medicare Allowable Amount)		Benefit is Limited to 2 admissions per Plan Year. Limit combined with Oupatient Surgery - Facilty and Chemical Dependency - Outpatient Facility. **Patient may be balance billed if the provider does not accept 140% of Medicare Allowable Payment
*D	*Outpatient Surgery - Facility, includes Free Standing	$350 Copay, then Plan pays 100% of Allowed Amount (**Plan payment is based on 140% of Medicare Allowable Amount)		Limited to 2 surgeries per Plan Year. **Patient may be balance billed if the provider does not accept 140% of Medicare Allowable Payment
*D	*Outpatient Surgery performed in an office	$350 Copay, then Plan pays 100% of the PPO Amount	No Benefit	
	Urgent Care Center & 24 Hours	$35 Copay, then Plan pays 100% of the PPO Amount	No Benefit	Limit of 3 visits per Plan Year

Prescription Drugs		
Prescription Benefits	**Preventative Prescription Drugs**: $0 Copay (Limited to Generic Preventive Only)	
	Preferred Prescription Drugs: Tier 1: $0 (over 200 drugs) Tier 2: $10 or less Tier 3: $25 or less (over 600 drugs) Tier 4: $50 or less	
	Additional Covered Drugs After Prescription Deductible: Formulary Generic: $10 Copay Formulary Brand: $30 Copay Subject to a combined separate prescription drug deductible of$1,000 per person / $2,000 per family Subject to a combined separate prescription drug maximum monthly benefit of $1,000 per person / $2,000 per family	

Virtual Care		
Telemedicine	$0 Copay	

Covered Preventive Services for Adults as defined by CMS Preventive Services			
Wellness Office Visits and Lab Services	**Network Providers**	**Out-of-Network Providers**	**Benefit Limits**
Office Visit Exam & Includes Services For:	Plan pays 100%	No Benefit	Limited to preventive diagnosis only.
Abdominal Aortic Aneurysm	Plan pays 100%	No Benefit	One time screening for males of ages 65 to 75 who have ever smoked
Alcohol Misuse Screening and Counseling	Plan pays 100%	No Benefit	
Aspirin use for Men and Women	Plan pays 100%	No Benefit	A low-dose aspirin for prevention of cardiovascular disease and colorectal cancer in adults aged 45-59 years (See plan document for further criteria.)
Blood Pressure Screening	Plan pays 100%	No Benefit	One screening every two years for ages 18 to 39 One Screening per Plan year for ages 40 and over
Cholesterol Screening	Plan pays 100%	No Benefit	One screening per Plan year for men 35 and older. Men under 35 who have heart disease or risk factors for heart disease or women who have heart disease or risk factors for heart disease
Colorectal Cancer Screening	Plan pays 100%	No Benefit	Screening for adults over age 45 **No Benefits for services provided in a hospital.**

Depression Screening	Plan pays 100%	No Benefit	Screening for depression in the general adult population, including pregnant and postpartum women.
Type 2 Diabetes Screening	Plan pays 100%	No Benefit	Screening for adults with high blood pressure only
Diet Counseling	Plan pays 100%	No Benefit	Screening for adults at higher risk of chronic disease
Hepatitis B Screening	Plan pays 100%	No Benefit	For members at high risk, including members in countries with 2% or more Hepatitis B prevalence, and U.S. Born people not vaccinated as infants with at least one parent born in a region with 8% or more Hepatitis B prevalence
Hepatitis C Screening	Plan pays 100%	No Benefit	For adults at increased risk, and one time for everyone born between 1945 - 1965
HIV Screening	Plan pays 100%	No Benefit	Screening for adults at higher risk
Immunizations * Hepatitis A * Hepatitis B * Herpes Zoster * Human Papillomavirus * Influenza (Flu Shot) * Measles, Mumps, Rubella * Meningococcal * Pneumococcal * Tetanus, Diphtheria, Pertussis * Varicella	Plan pays 100%	No Benefit	Listed immunizations are once per Plan year. Human Papillomavirus shots up to age 26. Pneumococcal shots for adults 65 and older
Latent Tuberculosis Infection	Plan pays 100%	No Benefit	Screening for latent tuberculosis infection (LTBI) in populations at increased risk
Lung Cancer Screening	Plan pays 100%	No Benefit	For adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
Obesity Screening and Counseling	Plan pays 100%	No Benefit	
Sexually Transmitted Infection (STI) Screening and Counseling	Plan pays 100%	No Benefit	Prevention counseling for adults at higher risk
Statin	Plan pays 100%	No Benefit	Adults aged 40-75 years with no history of cardiovascular disease (CVD) use a low-to moderate-dose statin for the prevention of CVD events and mortality when they have one or more cardiovascular disease risk factors, and a calculated 10-year CVD event risk of 10% or greater; screening for cardiac risk may include assessment of blood pressure, smoking status, screening for lipid disorders and use of ACC/AHA CVD to estimate 10-year risk
Syphilis Screening	Plan pays 100%	No Benefit	For all adults at higher risk
Tobacco Use Screening	Plan pays 100%	No Benefit	Screenings for adults and cessation interventions for tobacco users

Covered Preventive Services for Women - Including Pregnant Women			
Wellness Office Visits and Lab Services	**Network Providers**	**Out-of-Network Providers**	**Benefit Limits**
Well-Women Visits	Plan pays 100%	No Benefit	
Anemia Screening	Plan pays 100%	No Benefit	For pregnant women
BRCA Counseling	Plan pays 100%	No Benefit	Includes genetic test for women at high risk **No Benefits for services provided in a hospital.**
Breast Cancer Mammography Screening	Plan pays 100%	No Benefit	Screenings every 1 to 2 years for women over 40 through age 74. (See plan document for further criteria.) **No Benefits for services provided in a hospital.**
Breast Cancer Chemoprevention Counseling	Plan pays 100%	No Benefit	Counseling for women at high risk
Breast Pumps	Plan pays 100%		One per delivery. Purchase Breast Pump at a local retail store and submit the receipt for reimbursement
Breastfeeding Consultations	Plan pays 100%	No Benefit	Providing interventions during pregnancy and after birth to support breastfeeding. Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women.
Cervical Cancer Screening	Plan pays 100%	No Benefit	For ages 21-29, PAP smear every 3 years For ages 30-65, with cytology and human papillomavirus testing (HPV) with Pap smear every 5 years or a regular cytology alone (without HPV testing) every 3 years Women with an average risk shouldn't be screened more than once every 3 years
Chlamydia Infection Screening	Plan pays 100%	No Benefit	For younger women and women at high risk

Contraception	Plan pays 100%	No Benefit	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Counseling and follow-up care are included with this benefit. Birth control pills will be covered under your Rx benefits.
Domestic and Interpersonal Violence Screening	Plan pays 100%	No Benefit	Annual screening for women to obtain a referral to initial intervention services, which includes counseling, education, harm reduction strategies and referral to appropriate support services.
Folic Acid Supplements	Plan pays 100%	No Benefit	All women who are planning or capable of pregnancy take a daily supplement containing 0.4-0.8mg
Gestational Diabetes Screening	Plan pays 100%	No Benefit	For women 24 to 28 weeks pregnant and / or at high risk of developing gestational diabetes should be screened prior to 24 weeks of gestation
Gonorrhea Screening	Plan pays 100%	No Benefit	For all women at higher risk
Hepatitis B Screening	Plan pays 100%	No Benefit	For pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV) Screening and counseling	Plan pays 100%	No Benefit	For women sexually active
Human Papillomavirus (HPV) DNA Test	Plan pays 100%	No Benefit	One test every 3 years for women with normal cytology results who are 30 or older
Osteoporosis Screening	Plan pays 100%	No Benefit	For women over age 60 or at high risk
Preeclampsia	Plan pays 100%	No Benefit	Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
Rh Incompatibility Screening	Plan pays 100%	No Benefit	For pregnant women and follow-up testing for women at higher risk
Sexually Transmitted Infection (STI) and Sexually transmitted Diseases (STD) Screening and counseling, includes Gonorrhea and Syphilis Screening	Plan pays 100%	No Benefit	Counseling for sexually active women
Sterilization for Women	Plan pays 100%	No Benefit	
Syphilis Screening	Plan pays 100%	No Benefit	For all pregnant women or other women at increased risk
Tobacco Use Screening and interventions	Plan pays 100%	No Benefit	
Urinary Tract or Other Infection Screening for Pregnant Women	Plan pays 100%	No Benefit	

Covered Preventive Services for Children			
Wellness Office Visits and Lab Services	**Network Providers**	**Out-of-Network Providers**	**Benefit Limits**
Office Visit Exam & Includes Services For:	Plan pays 100%	No Benefit	Limited to preventive diagnosis only
Alcohol and Drug Use Assessments	Plan pays 100%	No Benefit	
Autism Screening	Plan pays 100%	No Benefit	For children at 18 months to 24 months
Behavioral Assessments	Plan pays 100%	No Benefit	For children to age 18
Blood Pressure Screening	Plan pays 100%	No Benefit	For children to age 18
Cervical Dysplasia Screening	Plan pays 100%	No Benefit	For sexually active females
Congenital Hypothyroidism Screening	Plan pays 100%	No Benefit	For newborns
Contraception	Plan pays 100%	No Benefit	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Counseling and follow-up care are included with this benefit. Birth control pills will be covered under your Rx benefits.
Depression Screening	Plan pays 100%	No Benefit	Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years
Developmental Screening	Plan pays 100%	No Benefit	For children under age 3 and surveillance throughout childhood
Dyslipidemia Screening	Plan pays 100%	No Benefit	For children at high risk of lipid disorders
Fluoride Chemoprevention Supplements	Plan pays 100%	No Benefit	For children without fluoride in their water sources
Gonorrhea Preventive Medication for the Eyes of All Newborns	Plan pays 100%	No Benefit	
Hearing Screenings	Plan pays 100%	No Benefit	For all newborns
Height, Weight and Body Mass Index Measurements	Plan pays 100%	No Benefit	For children to age 18
Hematocrit or Hemoglobin Screening	Plan pays 100%	No Benefit	For children to age 18
Hemoglobinopathies of Sickle Cell Screening	Plan pays 100%	No Benefit	For all newborns
HIV Screening	Plan pays 100%	No Benefit	For sexually active children

Hypothyroidism Screening for Newborns	Plan pays 100%	No Benefit	
Immunizations: * Acellular Pertussis * Diphtheria, Tetanus, Pertussis * Haemophilus influenza type B * Hemophilia * Hepatitis A * Hepatitis B * Human Papillomavirus * Inactivated Poliovirus * Influenza (Flu Shot) * Measles, Mumps, Rubella * Meningococcal * Meningococcal B Vaccine * Pneumococcal * Rotavirus * Varicella	Plan pays 100%	No Benefit	For children to age 18
Interpersonal and Domestic Violence Screening	Plan pays 100%	No Benefit	Annual screening for women to obtain a referral to initial intervention services, which includes counseling, education, harm reduction strategies and referral to appropriate supportive services.
Iron Supplements	Plan pays 100%	No Benefit	For children ages 6 to 12 months at risk of anemia
Lead Screening	Plan pays 100%	No Benefit	For children at risk of exposure
Medical History	Plan pays 100%	No Benefit	For all children throughout development
Obesity	Plan pays 100%	No Benefit	Screening for obesity in children and adolescents six years and older and offer to refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status
Oral Health	Plan pays 100%	No Benefit	At risk assessment for your children ages newborn to age 10
Phenylketonuria (PKU) Screening	Plan pays 100%	No Benefit	For genetic disorders in newborns
Sexually Transmitted Infection (STI) Screening and Counseling	Plan pays 100%	No Benefit	For children at higher risk, includes gonorrhea preventive medication for newborn eyes
Syphilis Screening	Plan pays 100%	No Benefit	For all adolescents at higher risk
Tuberculin Testing	Plan pays 100%	No Benefit	For children at higher risk of tuberculosis to age 18
Vision Screening	Plan pays 100%	No Benefit	Screening at least once in all children ages three to five years to detect amblyopia or its risk factors

We believe this coverage is a Non-Grandfathered health plan under the Patient Protection and Affordable Care Act. (PPACA)

All claims are subject to plan provisions at the time of service. Any benefits quoted telephonically or in writing is not a quarantee of payment. Claims are determined upon receipt of the claim and any additional information required to make a benefit determination.

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Plan Limitations and Exclusions

Plan Exclusions

1. **Abortion.** Services, supplies, care, or treatment in connection with an abortion, unless the life of the mother is endangered by the continued Pregnancy, or the Pregnancy is the result of rape or incest.
2. **Adoption.** Any charges associated with Adoption.
3. **Acupuncture.**
4. **Alternative medicine/homeopathy**
5. **Any other medical service, treatment, or procedure not covered under this Schedule of Benefits.**
6. **Ambulance Charges, Ground or Air.**
7. **Alcohol or Drugs.** 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 or drugs. A person will be conclusively presumed to be under the influence of alcohol or drugs and such influence will be conclusively presumed to be a cause of the illness, condition, accident or injury for the purposes of this exclusion if:
    - **a.** Either the person's blood alcohol level was equal to or greater than the legal limit for driving in the state where the accident occurred, or
    - **b.** If a blood, urine, or other medically reliable test determines that there was any amount of illegal drugs in the person's system at the time of the cause or occurrence of the illness, condition, or accident.
    - **c.** The presence of alcohol or drugs may be determined by
        i. Tests performed by or for law enforcement authorities
        ii. Tests performed in the course of treating the person, or
        iii. Other reliable means.
    - **d.** The Plan Administrator in its sole discretion shall determine whether a claim is excluded under these rules. There need not be a determination or action by any other person or party as to criminal fault.
    - **e.** Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol or other substances.
    - **f.** This exclusion does not apply if the Injury resulted from an act of domestic violence.
    - **g.** Screening and counseling to reduce alcohol misuse will be covered under preventive care.
8. **Ambulatory Services.** Including dialysis treatment, respiration therapy, radiation, and chemotherapy.
9. **Aquatic or massage therapy**
10. **Bereavement Counseling Services and Supplies.**
11. **Cardiac Rehabilitation or Rehabilitation Services.**
12. **Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding**
13. **Chemical Dependence/Substance Abuse.**
14. **Chemotherapy or Radiation**
15. **Chiropractic Services/Spinal Manipulation.**
16. **Complications of Non-Covered Treatments.** Care, services, or treatment required as a result of complications from a treatment not covered under the Policy.
17. **Contact Lenses or Glasses Following Cataract Surgery.**
18. **Cosmetic Procedures.** A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and /or functions of the body which are lost or impaired due to an illness or injury.
19. **Counseling Services.** Counseling for educational, social, occupational, religious, or other maladjustments. Counseling for treatment of a gambling addiction. Sensitivity or stress management training, self-help training unless specifically stated in the Schedule of Benefits.
    - **a.** Counseling services mandated by the PPACA are covered as specifically stated in the Schedule of Benefits.
20. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or Custodial Care.
21. **Day Treatment.** Means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over

a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers alternative to Inpatient treatment.

22. **Dental Care.**
23. **Dialysis.**
24. **Durable Medical Equipment.**
25. **Educational or Vocational Testing.** Services for educational or vocational testing or training, except in regard to education and training for diabetic management.
26. **Emergency Room Services for non-emergent services.**
27. **Error.** This policy reserves the right to recover any payments made by this policy that were:
    a. Made in error, or
    b. Made to you or any party on your behalf where this policy determines the payment to you or any party is greater than the amount payable under this policy, or
    c. This policy has the right to recover against you if this policy has paid you or any other party on your behalf.
28. **Exams or Treatment Required by Third Party.** Physical, psychiatric, and psychological exams or treatments and related services that are required by third parties. For example, exams and tests that are required for recreational activities, employment, insurance, and school; court-ordered exams and services, except when they are medically necessary services.
29. **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Maximum Allowable Charge.
30. **Exercise Programs.** Exercise programs for treatment of any condition.
31. **Experimental.** Care and treatment that is either Experimental, Investigational, or Exploratory.
32. **Eye Care.** Radial keratotomy, Lasik surgery, or other eye surgery to correct refractive disorders. Lenses for the eyes and exams for their fitting.
33. **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses, toenails, and foot inserts.
34. **Foreign Travel.** Care, treatment, or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
35. **Genetic Testing.** To detect suspected genetic abnormalities in an unborn child for a mother over age 45. Also included is testing to identify hereditary gene for breast/ovarian cancer. All other genetic testing is excluded from coverage unless medically necessary. Genetic testing is only for women at high risk of BRCA gene mutation: (must meet at least one of the requirements.
    a. Only for women (men not covered)
    b. Testing only covers BRCA1 and BRCA2.
    c. Panel testing or testing for genes outside BRCA1/BRCA2 are not covered.
    d. Multi-gene testing (MGT) is not covered.
    e. Testing is only covered if certain criteria are met per NCCN guidelines:
    f. A family member with a BRCA1/2 gene mutation (or other inherited gene mutation linked to breast cancer)
    g. A personal history of breast cancer at age 45 or younger
    h. A personal history of triple negative breast cancer (breast cancer that is estrogen receptor-negative, progesterone receptor-negative and HER2-negative) diagnosed at age 60 or younger
    i. Ashkenazi Jewish heritage and a personal history of breast cancer
    j. A personal history of breast cancer at age 46-50 and a close family member (parent, sibling, child, grandparent, grandchild, uncle, aunt, nephew, niece or first cousin) diagnosed with breast cancer or aggressive prostate cancer at any age
    k. A personal history of breast cancer at any age and a close family member diagnosed with breast cancer at age 50 or younger
    l. A personal history of breast cancer at any age and 2 or more close family members diagnosed with breast cancer at any age
    m. A personal history of breast cancer at any age and a close family member diagnosed with pancreatic cancer or metastatic prostate cancer at any age
    n. A close family member diagnosed with breast cancer at age 45 or younger

o. A personal or family history of ovarian cancer, pancreatic cancer, aggressive prostate cancer or metastatic prostate cancer

p. A personal or family history of male breast cancer.

36. **Gene and Cell therapy**
37. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
38. **Grandchildren** This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).
39. **Hair Loss.** Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
40. **Hearing Aids**, Including Cochlear Implants and Hearing Examinations. Charges for services including exams and supplies in connection with hearing aids or cochlear implants.
41. **Home Health Care Services and Supplies.**
42. **Hospital Charges**. Any services billed from a hospital unless specifically stated otherwise in the Schedule of Benefits.
43. **Hospice Care Services** and Supplies or Bereavement Counseling.
44. **Illegal Acts.** Charges for services received for Injury or Sickness occurring directly or indirectly as a result of active participation in an Illegal Act, or active participation in a riot or public disturbance.
    - **a.** It is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment be imposed for this exclusion to apply.
    - **b.** Proof beyond a reasonable doubt is not required.
    - **c.** This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
    - **d.** Services received as a result of illness or injury caused or contributed to by the Covered Person committing or attempting to commit any of the following or engaging in conduct which would amount to any of the following if a charge had been made, regardless of whether a charge was filed or guilt was determined:
        i. A felony;
        ii. Any illegal occupation;
        iii. A misdemeanor or other offense involving theft, fighting, disorderly conduct, or other breach of the peace; or
        iv. A misdemeanor or other offense involving the use of alcohol or drugs, including, but not limited to any crime or offense involving driving or being in actual physical control of a motor vehicle or any other means of conveyance propelled in part or in whole by an engine or motor, for example, a boat or ATV, while under the influence of alcohol or drugs.
45. **Illegal Drugs or Medications.** Services, supplies, care, or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician.
    - **a.** Expenses will be covered for Injured Covered Persons other than the person using controlled substances.
    - **b.** This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
46. **Impotence.** Care, treatment, services, or supplies in connection with treatment for impotence.
47. **Infertility.** Care, supplies, services, and treatment for infertility, artificial insemination, or in vitro fertilization, unless listed as covered in the Schedule of Medical Benefits.
48. **Inpatient facility claims for surgery after the inpatient hospital day limit per plan year has been exhausted or reached.**
49. **Marital, Pre-Marital, or Family Counseling**. These services are not a covered benefit.
50. **Maternity coverage for dependent children**, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded.
51. **Neonatal intensive care (NICU)**
52. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
53. **No Obligation to Pay.** Charges incurred for which the policy has no legal obligation to pay.
54. **No Physician Recommendation.**
    - **a.** Care, treatment, services, or supplies not recommended and approved by a Physician; or

b. Treatment, services, or supplies when the Covered Person is not under the regular care of a Physician.

c. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

55. **Not Specified as Covered.** Non-traditional medical services, treatments, and supplies which are not specified as covered under this policy.
56. **Obesity.** Care and treatment of obesity, weight loss, or dietary control whether or not it is a part of the treatment plan for another Sickness.
    a. Specifically excluded are charges for Bariatric Surgery, including but not limited to:
        i. Gastric Bypass,
        ii. Stapling and Intestinal Bypass, and
        iii. Lap Band Surgery, including reversals.
        iv. Medically Necessary charges for Morbid Obesity will not be covered.
        v. Nutritional counseling will be covered under preventive care.
57. **Occupational.** Care and treatment of an Injury or Sickness that is occupational. Occupational means that it arises from work for wage or profit, including self-employment.
58. **Occupational Therapy.**
59. **Orthotic Appliances.**
60. **Oxygen.**
61. **Physical Therapy.**
62. **Plan Design Excludes.** Charges excluded by the policy design as mentioned in this document.
63. **Private Duty Nursing Care.**
64. **Private room unless medically necessary or if a semi-private room is not available.**
65. **Prosthetic Devices.** Purchase, fitting and repair of fitted prosthetic devices which replace body parts.
66. **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties
67. **Recreational or diversional therapy**
68. **Replacement Braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs.
69. **Residential Treatment Facilities.** Inpatient and outpatient services associated with Mental Health, Chemical Dependency and Substance Abuse.
70. **Respiration Therapy.**
71. **Sales Tax.**
72. **Self-Inflicted.** Any loss due to an intentionally self-inflicted injury.
73. **Services Before or After Coverage.** Care, treatment, or supplies for which a charge was incurred before a person was covered under this policy or after coverage ceased under this policy.
74. **Services deemed medically unnecessary.**
75. **Sex Changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical, or psychiatric treatment.
76. **Sexual Dysfunction.** Behavioral treatment or drug therapy for sexual dysfunction and sexual function regardless if cause of dysfunction is due to physical or psychological reasons.
77. **Skilled Nursing Facility** or Physician Care.
78. **Sleep Disorders or Studies.**
79. **Smoking / Tobacco Cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches. Counseling for tobacco use is covered under preventive care.
80. **Speech Therapy.**
81. **Surgical Services.** Surgical charges done in an outpatient setting are not covered.
82. **Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
83. **Surrogate Pregnancy Services.** Services incurred in connection with an agreement to act as a surrogate mother. This excludes pregnancy-related charges incurred by an insured who is acting as a surrogate mother as well as pregnancy-related charges incurred by a non-insured who is acting as a surrogate for an insured.

84. **TMJ or Orthognathic Services.** Treatment is not covered.

85. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician.

86. **Vision Therapy Services.** Services incurred to treat vision therapy is not covered.

87. **War.** Any loss that is due to a declared or undeclared act of war. Including nuclear reaction or the release of nuclear energy. This exclusion will not apply if the loss is sustained within 90 days of the initial incident. To be covered under the policy, the loss must be caused by fire, heat, explosion or other physical trauma that is a result of the release of nuclear energy. The covered person must be within a 25-mile radius of the release site at the time of the release or within 24 hours of the start of the release.

88. **Workers Compensation.** Injury or illness that is covered by any Workers Compensation or Occupational Disease law.