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## SCHEDULE OF BENEFITS - OPTION C – PPO OPTION

**Verification of Eligibility:** Call 210-697-9900 (outside San Antonio, Texas, call 1-800-934-6302). Call this number to verify eligibility for Plan benefits **before** the charge is Incurred. Option C is only available to eligible employees who are not eligible to enroll in Option A because they do not reside, live or work within the service area served by Option A.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Karin Frye, Plan Administrator, WellMed Medical Management at (210) 617-4702.

In addition, if the plan requires the employee to decline coverage in writing, the notice must also state that.

### MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Plan provisions, exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are limited to the amount the Plan Administrator determines are the Usual and Reasonable Charges; and that services, supplies and care are not Experimental and/or Investigational.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Covered Person, at no cost, who requests one from the Plan Administrator. The Summary Plan Description is also available on the WellMed Medical Management intranet and the internet website [www.wellmedmedicalgroup.com](http://www.wellmedmedicalgroup.com)

**Note: The following services must be precertified or reimbursement from the Plan may be reduced.**

**Hospitalizations  
Skilled Nursing Facility Stays  
Outpatient Surgery  
Transplants and Transplant Evaluation  
Home Health Care**

**Please see the "Cost Management Services" section in this booklet for details.**

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called "Participating Providers" or "Network Providers." Because these Participating Providers have agreed to charge reduced fees to Covered Persons, the Plan can afford to reimburse a higher percentage of their fees. **Refer to your ID card for information on Participating Providers.** When a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a non-Participating Provider is used.

Under the following circumstances, the higher in-Network Provider payment will be made for certain non-Network Provider services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the Network Provider service area.

If a Covered Person is out of the Network Provider service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives ancillary or anesthesia services from a non-Network Provider at an in-Network Provider facility.

Additional information about this option, as well as a list of Participating Providers, will be given to Covered Persons, at no cost, and updated as needed.

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

**Deductibles/Coinsurance payable by Covered Persons**

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A "deductible" is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan, and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required. Co-payments and Prescription Drug Co-payments do not accrue toward the 100% maximum out-of-pocket payment.

"Coinsurance" is the percentage of the Contracted Charges or of the Usual and Reasonable Charges for a Non-Participating Provider.

"Co-payments" are dollar amounts that the Covered Person must pay before the Plan pays. A "co-payment" is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments.

Network participating providers may not bill above the contracted rates, provided you pay your coinsurance at the time of service or promptly when billed.

	<b>NETWORK PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b>
<b>MAXIMUM LIFETIME BENEFIT AMOUNT</b>	\$2,000,000	
<b>Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating providers.</b>		
<b>Co-payments</b>		
For all services rendered in the physician's office there will be only one co-payment taken per visit. All other services ordered by the physician and performed outside of the physician's office are not included under the physician's visit co-payment.		
<b>DEDUCTIBLE, PER CALENDAR YEAR</b>		
Per Covered Person	\$250	\$500
Per Family Unit	\$500	\$1,000
In Network and Out of Network deductibles accumulate separately		
<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</b>	The in network calendar year deductible and in-network co-insurance paid by you apply toward the In-Network Out-of-Pocket Maximum	The out of network deductible and out of network co-insurance paid by you apply toward the Out of Network Out-of-Pocket Maximum

	<b>NETWORK PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b>
Per Covered Person	\$1,500	\$3,000
Per Family Unit	\$3,000	\$6,000
The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. In-Network and Out-of-Network expenses toward satisfying the Out-of-Pocket Maximum accumulate separately		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Office Visit Co-payment Urgent Care Co-payment ER Co-payment Prescription Drug Plan Co-payments Cost containment or failure to preauthorize penalties Non Covered Services		
<b>FAILURE TO PREAUTHORIZE PENALTY</b>		
In-Network	\$250	
Out-of-Network	\$500	
Applies to each service or supply for which preauthorization is required but was not obtained		
The co-payment for Physician visits and Urgent Care centers applies to all services rendered in a physician's office, including all laboratory and x-ray associated with the visit. Complex Imaging, as defined, and chemotherapy services/supplies and radiation therapy services/supplies are subject to the Calendar Year deductible and co-insurance.		
Physician Office Visits	\$20 co-payment	Deductible and co-insurance
Urgent Care Center	\$50 co-payment	Deductible and co-insurance
Emergency Room	\$100 co-payment (covers the facility and physician charges)	\$300 co-payment (covers the facility and physician charges)
The Emergency room co-payment is waived if the patient is admitted to the Hospital and deductible and co-insurance will apply. The utilization review administrator, Medical Cost Management, must be notified at 1-800-367-9938 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
<b>COVERED SERVICES</b>	<b>The Plan pays based upon (1) the Contracted Rate for In-Network Providers and (2) the Reasonable and Customary Charge for Non-Network Providers:</b>	
<b>Physician Services</b>		
Primary Care Physician Office visits	100% after \$20 co-payment	60% after you satisfy the Deductible
Pediatrician Physician Office visits	100% after \$20 co-payment	60% after you satisfy the Deductible
Newborn Care-Inpatient	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Specialist Office Visits	100% after \$20 co-payment	60% after you satisfy the Deductible
Maternity Office Visit	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Immunizations	100% after \$20 co-payment	60% after you satisfy the Deductible
Inpatient visits	90% after you satisfy the Deductible	60% after you satisfy the Deductible

	<b>NETWORK PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b>
Allergy testing	100% after \$20 co-payment	100% after you satisfy the Deductible
Allergy serum and injections	100% after you satisfy the Deductible	100% after you satisfy the Deductible
Emergency Room Physician	90% after you satisfy the Deductible	60% after you satisfy the Deductible
<b>FAMILY PLANNING SERVICES</b>		
Sterilization (tubal ligation or vasectomy)	Benefit determined by place of service	60% after you satisfy the Deductible
Injectable/IUD Birth Control Drugs	\$20 co-payment per visit	60% after you satisfy the Deductible
Fertility/Infertility Diagnosis	100% after \$20 co-payment	60% after you satisfy the Deductible
Artificial Insemination	Artificial Insemination is limited to a lifetime maximum of three (3) rounds at 50% of allowable expenses. In vitro Fertilization is not Covered.	60% after you satisfy the Deductible; Artificial Insemination is limited to a lifetime maximum of three (3) rounds at 50% of allowable Usual and Reasonable Expenses. In vitro Fertilization is not Covered.
<b>HOSPITAL SERVICES</b>		
Inpatient Services	90% of the semi-private room rate after you satisfy the Deductible	60% of the semi-private room rate after you satisfy the Deductible
Outpatient Services	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Outpatient Surgery Services	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Emergency Room	\$100 per visit co-payment	\$300 per visit co-payment
Skilled Nursing Facility	90% of the facility's semi-private room rate after you satisfy the Deductible; 100 day Calendar Year Max	60% of the facility's semi-private room rate after you satisfy the Deductible; 100 day Calendar Year Max
Urgent Care	\$50 co-payment	60% after you satisfy the Deductible
Intensive Care	90% of the Hospital's ICU charge after you satisfy the Deductible	60% of the Hospital's ICU charge after you satisfy the Deductible
<b>Diagnostic &amp; Preventative Laboratory &amp; X-ray Services</b>	\$20 co-payment at facility	60% after you satisfy the Deductible
<b>Radiological Services</b> (Dexa, Mammogram, Ultrasound, MRI, MRA, PET, CT, Nuclear Medicine, etc.)	90% after you satisfy the Deductible	60% after you satisfy the Deductible
<b>Home Health Care</b>	90% after you satisfy the Deductible; 60 visit Calendar Year Max	60% after you satisfy the Deductible; 60 visit Calendar Year Max

	<b>NETWORK PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b>
<b>Durable Medical Equipment</b> (including Oxygen)	90% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max	60% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max
Diabetic Supplies	Covered under the terms of the RX program and/or Disease Management program	60% after you satisfy the Deductible
<b>Physical Therapy, Hearing Therapy, Occupational Therapy, Speech Therapy</b> (any setting)	90% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max	60% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max
<b>Prosthetic-Orthopedic Appliances</b>	90% after you satisfy the Deductible; \$5000 Calendar Year per Covered Person Max	60% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max
<b>Dialysis Services</b>	90% after you satisfy the Deductible	60% after you satisfy the Deductible
<b>Chemotherapy</b>	90% after you satisfy the Deductible	60% after you satisfy the Deductible
<b>Radiation therapy</b>	90% after you satisfy the Deductible	60% after you satisfy the Deductible
<b>Hospice Care</b>	90% after you satisfy the Deductible; Lifetime Max of \$10,000 for both inpatient and outpatient	60% after you satisfy the Deductible; Lifetime Max of \$10,000 for both inpatient and outpatient
<b>Ambulance Services</b> (medical emergency services only)	\$50 co-payment per trip or visit	\$50 co-payment per trip or visit
<b>Mental Disorders</b>		
Inpatient (limited to 30 days per admission)	90% after you satisfy the Deductible; 30 day Calendar Year Max	60% after you satisfy the Deductible; 30 day Calendar Year Max
Outpatient (limited to 20 visits)	90% after you satisfy the Deductible; 20 visit Calendar Year Max	60% after you satisfy the Deductible; 20 visit Calendar Year Max
<b>Serious Mental Illness</b>		
Inpatient	90% after you satisfy the Deductible; limited to 45 days per Calendar Year	60% after you satisfy the Deductible; limited to 45 days per Calendar Year
Outpatient	90% after you satisfy the Deductible; limited to 60 visits per Calendar Year	60% after you satisfy the Deductible; limited to 60 visits per Calendar Year
<b>Chemical Dependency/Substance Abuse</b>		
Inpatient (limited to 30 days Max)	90% after you satisfy the Deductible up to \$5,000 Max	60% after you satisfy the Deductible up to \$5,000 Max
Outpatient (limited to 30 days Max)	90% after you satisfy the Deductible up to 24 visits Max	60% after you satisfy the Deductible up to 24 visits Max
Chemical Dependency or Substance Abuse treatment is limited to three (3) series of treatment per Lifetime and three (3) days of detoxification per admission		
<b>Organ Transplants</b> Limited to human to human organ or tissue transplant procedures	90% after you satisfy the Deductible	60% after you satisfy the Deductible

	<b>NETWORK PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b>
<b>Organ Transplant Donor</b>	90% after you satisfy the Deductible; limited to \$5,000 for donor expenses	6% after you satisfy the Deductible; limited to \$5,000 for donor expenses
<b>Retail Pharmacy *</b> 30 day supply	\$10 co-payment for generic if you obtain from the lowest cost pharmacy in your area  \$30 co-payment for brand if you obtain from the lowest cost pharmacy in your area	None
<b>Mail Order Pharmacy</b> 90 day supply	\$10 co-payment for generic \$60 co-payment for brand	None
<b>All other eligible expenses that are Covered Expenses and not Excluded</b> 90% after you satisfy the Deductible 60% after you satisfy the Deductible		

\* The Retail Pharmacy must be the lowest cost pharmacy in your area to receive the prescription on this basis.

#### **VISION BENEFITS**

<b>MAXIMUM BENEFIT, PER CALENDAR YEAR</b>	
Per covered person	\$250 combined maximum for exam and eyewear
<b>BENEFIT DESCRIPTION</b>	
<b>Comprehensive Eye Exam</b>	
(Eye exam limited to one per calendar year)	
<b>Eyewear</b>	
(includes frames, lenses, and contacts)	

## COVERED CHARGES

"Covered Charges" are the Medically Necessary, Usual and Reasonable Charges that are Incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions (including the pre-existing condition exclusion) and other provisions of this Plan.

- (1) **Ambulance Services.** Medically necessary land or air ambulance service will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where Medically Necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (2) **Anesthesia services.**
- (3) **Birth control implants and devices.** Services or supplies in connection with birth control implants and devices including their removal.
- (4) **Blood and blood derivatives.** Charges for these services will be covered to the extent that they are not donated or replaced.
- (5) **Cardiac rehabilitation.** Charges for these services when determined to be Medically Necessary, provided the services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility.
- (6) **Chemotherapy.**
- (7) **Diabetic Supplies.** Charges for diabetic lancets, diabetic glucose testing strips, and glucose monitors.
- (8) **Durable Medical Equipment or surgical equipment.** Charges for the rental or purchase of equipment when it is determined to be Medically Necessary. These items are normally rented, but may be purchased rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
- (9) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.  
  
A Home Health Care visit is a periodic visit by a nurse, a home health aid or a therapist.
- (10) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.
- (11) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. After 23 observation hours, a confinement will be considered an inpatient confinement.  
  
Room charges made by a Hospital having only private rooms will be paid at 90% of the average private room rate.
- (12) **Intravenous injections and solutions.**
- (13) **Laboratory Studies.**

(14) **Mental Disorders and Substance Abuse/Serious Mental Illness.** Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

(a) All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

(b) Physician's visits are limited to one treatment or visit per day.

(c) Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of, and must bill the Plan through, these professionals. Serious Mental Illness Care is described below.

(d) **Serious Mental Illness Care** is care or treatment for schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence. All treatment of Serious Mental Illness is subject to the maximums and limits shown in the Schedule of Benefits. Only the providers listed in (c) above are eligible for reimbursement under the plan for treatment of Serious Mental Illness. Mental Disorders and Serious Mental Illnesses must be for a diagnosis recognized in the Diagnostic and Statistical Manual – 4<sup>th</sup> Edition ("DSM-IV").

(15) **Occupational therapy.** Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Services must be rendered by a licensed occupational therapist. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(16) **Oral Surgery.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

(17) **Organ transplants.** Charges otherwise covered under the Plan that are Incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan.

Donor charges include those for:

Evaluating the organ or tissue;

Removing the organ or tissue from the donor; and

Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

- (18) **Oxygen.**
- (19) **Physical therapy.** The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions, which are expected to improve through short-term therapy. Services must be rendered by a licensed physical therapist.
- (20) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

- (i) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
  - (ii) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Usual and Reasonable Charge allowed for that procedure; and
  - (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable Charge.
- (21) **Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.
  - (22) **Prescription Drugs.** Coverage is subject to the limits and exclusions provided herein.
  - (23) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:
    - (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial Care and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
    - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial Care. The only charges covered for Outpatient Care are those shown below, under Home Health Care Services and Supplies.
  - (24) **Prosthetic Devices.** The initial purchase, fitting and repair of **artificial devices**, which replace natural body parts.
  - (25) **Radiation therapy.**
  - (26) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties following a Medically Necessary mastectomy will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,

- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including treatment for lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

(27) **Routine Preventive Care.** Covered Charges under Medical Benefits are payable for routine preventive care as described in the Schedule of Benefits.

(28) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a) the patient is confined as an inpatient in the facility;
- (b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (c) the attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits.

(29) **Speech therapy.** Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. Therapy must be rendered by a licensed speech therapist.

(30) **Sterilization** procedures

(31) **Surgical dressings,** splints, casts and other devices used in the reduction of fractures and dislocations.

(32) **Vision Care Expenses.** Expenses for routine vision care, including annual eye exams, glasses, and contact lenses. .Charges for the initial contact lenses or glasses following cataract surgery.

(33) **Well Newborn Nursery/Physician Care.**

**Charges for Routine Nursery Care.** Routine well newborn nursery care and Physician care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital or a Physician makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care, from both the Hospital and the Physician, will be applied toward the Plan of the covered parent.

(34) **Maternity Care.** Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the

mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans may not, under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## PRESCRIPTION DRUG BENEFITS

### Pharmacy Benefit Manager (PBM)

Prescription drug expenses are handled through a PBM who is contracted with by the Plan. Information will be furnished to you regarding the name of the PBM and how to access their services. The PBM has contracted with the Plan to provide Covered Persons with access to covered Prescription Drugs.

When you obtain a prescription from a physician, you will contact the PBM through their toll free telephone number that will be provided. The PBM will provide you with information directing you to the pharmacy in your area with the lowest price for your prescriptions. You will know the price of the prescriptions before you buy them.

### Co-payments

If you choose to buy your prescription at the lowest cost pharmacy in your area, you will pay the applicable co-pay. If you decide on another, more expensive pharmacy, you will pay the difference between the lowest price at the lowest cost pharmacy and the price of the more expensive pharmacy.

Any amount paid as a co-payment under the Prescription drug plan is not covered under the Medical Plan. The prescription drug co-payments do not accumulate to the maximum out-of-pocket per Calendar Year.

### Emergency/Out-of Area

If you are out of the area and require prescription drugs as a result of the emergency there will pay the applicable co-pay.

### Mail Order Drugs/Maintenance Medication

Maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, high cholesterol, etc.) will be provided through a mail order service through the PBM. In most instances, the cost of getting the medication through the mail order service is the least expensive. If this is the case, and you purchase your prescriptions through the mail order service, you will pay the applicable co-pay. If you choose to purchase your prescription at a more expensive retail pharmacy, you will pay the difference between the lower price offered by the mail order service and the higher price of retail pharmacy and you will pay this co-pay each time you refill the prescription and only receive a 30 day supply.

### Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law except for those drugs stated as not covered under this Plan. See "Expenses Not Covered" section of this document.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician.

### Limits to This Benefit

The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

## **Prescription Drug, Pharmaceutical and Other Supplements and Devices for which the Expense Is Not Covered**

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** Appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Dietary Supplements.** Charges for dietary supplements, including vitamins (except prenatal), and fluoride supplements.
- (6) **Drugs administered by the prescriber.** Charges for medications or drugs delivered or administered by the prescriber.
- (7) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (8) **Elective Enhancement.** Elective or voluntary enhancement procedures, services, supplies and medications, including, but not limited to, weight loss, hair growth, sexual performance, cosmetic purposes, anti-aging, and mental performance, including medicines to treat erectile dysfunction, impotency, anorgasm or hyporgasm.
- (9) **Experimental.** Experimental and/or Investigational drugs and medicines, even though a charge is made to the Covered Person, including any drug not approved by the FDA.
- (10) **FDA.** The United States Food and Drug Administration.
- (11) **Growth hormones.** Charges for drugs to enhance physical growth, athletic performance or appearance.
- (12) **Immunization.** Immunization agents or biological serum.
- (13) **Impotence.** A charge for impotence medication.
- (14) **Infertility.** A charge for infertility medication, including injectable infertility drugs.
- (15) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- (16) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (17) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (18) **Lost or stolen prescriptions.** A charge to replace a lost or stolen prescription.
- (19) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

- (20) **No charge.** A charge for Prescription Drugs that may be properly received without charge under local, state or federal programs.
- (21) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (22) **No prescription.** A drug or medicine that can legally be bought without a written prescription, including non-prescription contraceptive shields, ointments or forms. This does not apply to injectable insulin. This also applies to drugs for which there is a non-prescription equivalent available, even if ordered by a physician.
- (23) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (24) **Saline.** Any charge for saline and medications for irrigation.
- (25) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.
- (26) **Therapeutic devices or appliances.** A charge for a therapeutic device or appliance, including, but not limited to, hypodermic needles, syringes, support garments, other non-medicinal substances, pen fills, pen needles, insulin pen devices, insulin pumps and related supplies (other than diabetic supplies).
- (27) **While Not Covered.** A charge for a drug or medication purchased and received prior to the date the Covered Person became covered or after the Covered Person's coverage ceased under the Plan.
- (28) **Workers' Compensation.** A charge for a medicine for which the cost is recoverable under workers' compensation or occupational disease law or any state or government agency or any medication furnished by any other drug or medical service for which no charge is made to the patient.

## COST MANAGEMENT SERVICES

### Cost Management Services – Option C-PPO

**Cost Management Services Phone Number:** Please call Benefit Management Administrators at 1-210-697-9900 in San Antonio, Texas, and 1-800-934-6302 for outside of San Antonio, Texas.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 7 days in advance of non-emergency services being rendered or within 48 hours after an emergency.

**Any reduced reimbursement or failure to precertify penalty due to failure to follow cost management procedures will not accrue toward the out-of-pocket maximum.**

### UTILIZATION REVIEW

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

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:
  - Hospitalizations
  - Substance Abuse/Mental Disorder treatments
  - Skilled Nursing Facility stays
  - Home Health Care, including Private Duty Nursing
  - Hospice Care, including Private Duty Nursing
  - Transplant Evaluations/surgery
  - Outpatient surgery
- (b) Retrospective review of the Medical Necessity of the services provided on an emergency basis;
- (c) Concurrent review, based upon the admitting diagnosis, of the services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges, the Plan will impose a failure to precertify penalty or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

In order to maximize Plan reimbursements, please read the following provisions carefully.

### **Here's how the program works.**

**Precertification.** Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 7 days before** non-emergency services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** following the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by \$250 if a Network Provider is used and \$500 if a Non-Network Provider is used

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request approval of the additional services or days.

## PLAN EXCLUSIONS

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

**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:**

- (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) **Acupuncture or Acupressure.** Services or supplies in connection with acupuncture or acupressure.
- (3) **Administration or Injection Charge.** A charge for drug administration or injection, unless it is explicitly covered in the schedule of benefits.
- (4) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness that occurred while the Covered Person used or was under the influence of alcohol. The arresting officer's determination of inebriation, or a blood alcohol content in excess of the applicable legal limit, will be sufficient for this exclusion to apply. Expenses will be covered for injured Covered Persons other than the person using or being under the influence of alcohol. Expenses will be covered for Substance Abuse treatment as specified in this Plan for the Covered Person who was arrested or charged with using alcohol. 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.
- (5) **Behavioral modification.** Services, supplies, care or treatment for behavioral modification, communication delays, conduct problems, education therapy, developmental delays, autism, special education, counseling, therapy or training.
- (6) **Chelation or Metallic ion therapy.** Services or supplies in connection with chelation or metallic ion therapy, except for treatment of acute metal poisoning.
- (7) **Breast Reduction surgery.** Any charges incurred in connection with surgery for breast reduction whether or not it is deemed to be medically necessary.
- (8) **Circumcision.** A charge for circumcision, unless it is performed within six months following birth.
- (9) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (10) **Cosmetic Surgery or Treatment.** Charges incurred in connection with the care or treatment of, or operations which are performed for Cosmetic purposes of any kind including treatment or surgery for complications or correction of cosmetic surgery or treatment, except: (a) to correct a congenital anomaly in a child born, adopted or placed for adoption and which is covered as a Dependent and to whom no pre-existing condition exclusion or limit applies; (b) for reconstructive breast surgery; (c) or from Injuries sustained in an accident.
- (11) **Custodial care.** Services or supplies provided mainly as a rest care, maintenance or Custodial Care.
- (12) **Dental care.** A charge for any medical care in connection with dental treatment unless such care is:
  - (a) required for repair or replacement of sound natural teeth damaged by an Injury; or
  - (b) in connection with congenital defects, malformations or abnormalities present at birth.

(excluded services include dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, and preparing the mouth for fitting of or continued use of dentures.)
- (13) **Educational or vocational testing.** Services for educational or vocational testing or training.

- (14) **Employment or insurance testing.** A charge incurred for an employment or insurance purpose.
- (15) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (16) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (17) **Experimental or not Medically Necessary.** Care and treatment that is Experimental and/or Investigational or not Medically Necessary. The term “Experimental” when used in reference to a drug, device, treatment and/or a procedure means a drug, device, treatment and/or a procedure that satisfies one or more of the following:

- (a) a drug or device that cannot be lawfully marketed for the proposed use without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug or device is furnished or which was not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

- (b) a drug, device, treatment or procedure which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility’s Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility’s Institutional Review Board or other body serving a similar function; or

- (c) a drug, device, treatment or procedure which Reliable Evidence shows is the subject of an on-going Phase I, II or III clinical trial set forth in the FDA regulations or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

- (d) a drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

- (e) the treatment or procedure is less effective than conventional treatment methods; or

- (f) a review of the number of patients who have received this treatment indicates that the patients who have received the treatment or procedure, received it during Phase I, II or III of the clinical trial of the development of the treatment or procedure; or

- (g) the procedure or treatment is currently undergoing review by the Institutional Review Board (or similar body) for the treating health care facility; or

- (h) the language appearing in the consent form or in the treating Hospital’s protocol for treatment indicates that the Hospital or the Physician regards the treatment or procedure as experimental.

“Reliable Evidence” means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent form used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure with respect to the condition of the Covered Person in question.

The Claims Administrator, in its judgment, may deem an Experimental service to be covered under this Plan for treating a life threatening sickness or condition if it is determined by the Claims

Administrator that the Experimental service at the time of the determination: (i) is proven to be safe with promising efficacy; and (ii) is provided in a clinically controlled research setting; and (iii) uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. For purposes of this section, “life threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.

- (18) **Eye care.** Radial keratotomy, LASIK or other eye surgery to correct refractive disorders. Also included are orthoptic, keratimileusis, and keratophakai.
- (19) **Eye exercises (vision therapy).** Services or supplies in connection with eye exercises for correcting faulty eye coordination (orthoptics).
- (20) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (21) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (22) **Gene manipulation therapy.** Services or supplies in connection with gene manipulation therapy.
- (23) **Generally accepted standards of medical practice.** A charge for services or supplies that do not meet generally accepted standards of medical practice.
- (24) **Genetic testing.** Counseling or treatment, except in connection with an existing Pregnancy.
- (25) **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.
- (26) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (27) **Hair Loss Treatment.** Minoxidil (Rogaine) or Propecia or any other medication or drugs used for the treatment of alopecia.
- (28) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan. Charges for hearing disorders including cochlear implants.
- (29) **Holistic and naturopathic medicines.** Services or supplies in connection with holistic or naturopathic treatment.
- (30) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (31) **Hypnotherapy, behavior training, sleep therapy** (unless sleep apnea or narcolepsy is the diagnosis) and similar programs.
- (32) **Illegal acts.** Charges for services received as a result of Injury or Sickness that occurred while the Covered Person was engaging in an illegal act or occupation, committing or attempting to commit any crime, criminal act, assault or other felonious behavior or participating in a riot or public disturbance. 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. This exclusion applies even if the individual is not charged, convicted, or arrested if the Plan Administrator obtains knowledge of facts that could give rise to a charge for an illegal act or occupation or that the individual attempted to commit or

committed any crime, criminal act, assault, or other felonious behavior or participated in a riot or public disturbance.

- (33) **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. Expenses will be covered for injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. 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.
- (34) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence, erectile dysfunctions, sexual dysfunctions or inadequacies. This exclusion includes care, treatment, supplies, medications, implants and devices, whether or not Medically Necessary or following surgery.
- (35) **Infertility.** Care, supplies, services and treatment for invitro fertilization.
- (37) **Late Filed Claims.** Any claim for any medical care, service or supply that is received by the Plan's Claim Administrator more than twelve (12) months from the date on which the service(s) were rendered or incurred or the supplies or equipment were provided; except that any claim by the Center for Medicare and Medicaid Services, the Department of Health and Human Services or one of their contractors under the Medicare Secondary Payer statute must be submitted within three (3) years of the date on which the claim was incurred.
- (38) **Marriage or Family counseling.** Services or supplies in connection with marriage or family counseling.
- (39) **Massage therapy or rolfing.** Services or supplies in connection with massage therapy or rolfing.
- (40) **Military duty.** A charge incurred as the result of military duty.
- (41) **More than one OB/GYN annual exam visit per year.** Routine gynecological exams in excess of one (1) per twelve (12) month period unless ordered by a Covered Person's physician.
- (42) **Motorized wheelchairs and beds.** A charge for a motorized wheelchair or bed or any other Durable Medical Equipment not covered within the limits of the Schedule of Benefits.
- (43) **Nerve or muscle stimulators.** Services or supplies in connection with nerve or muscle stimulators. This includes electronic brain stimulators for the diagnosis of Parkinson's disease, dorsal column stimulators, and implantable pain pumps.
- (44) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (45) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (46) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (47) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. "Regular care" means on-going medical supervision or treatment that is appropriate care for the Injury or Sickness.

- (48) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan. Any treatment, service or supply not described as covered under this Plan.
- (49) **Obesity.** Weight loss or dietary control programs, weight reduction surgery and surgery alternatives for treatment of Obesity or Morbid Obesity whether or not it is, in any case, a part of the treatment plan for another sickness which may be helped by weight reduction.
- (50) **Occupational.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment, for which the Covered Person is entitled to benefits under any worker’s compensation, U.S. Longshoremen and Harbor Worker’s or other occupational disease legislation or policy, whether or not such policy is actually in force.
- (51) **Orthotics.** Charges in connection with orthotics, unless determined to be medically necessary for diabetic foot disease with neuropathy.
- (52) **Orthognathic Surgery.** All orthognathic surgical procedures.
- (53) **Outpatient Disposable or Consumable Medical Supplies, Food or Nutritional Supplements.** Charges for outpatient disposable or consumable medical supplies, food or nutritional supplements.
- (54) **Outside U.S.** A charge incurred outside the United States when the Covered Person traveled to the location for the purpose of obtaining drugs, services or supplies.
- (55) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, and first-aid supplies and non-hospital adjustable beds.
- (56) **Plan design exclusions.** Charges excluded by the Plan design as set forth in this document, such as Pre-existing Conditions during the Pre-existing Condition Exclusion period that applies to the Covered Person.
- (57) **Pregnancy of daughter.** Care and treatment of Pregnancy and complications of Pregnancy for a dependent daughter only.
- (58) **Private Duty Nursing.** A charge for private duty nursing.
- (59) **Psychological Testing.** Charges for psychological testing including I.Q. testing
- (60) **Psychosurgery.** Charges for psychosurgery.
- (61) **Relative giving services.** Professional services performed or authorized by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (62) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (63) **Reversal of Sterilization.** Charges resulting from or in connection with the reversal of a sterilization procedure or any form of contraceptive, unless specified in the Schedule of Benefits.
- (64) **Riot or Insurrection.** Any charge incurred as the result of participation in a riot or insurrection.

- (65) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. 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.
- (66) **Services before or after coverage.** Care, treatment or supplies for which a charge was Incurred before a person was Covered under this Plan or after coverage ceased under this Plan.
- (67) **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.
- (68) **Sexual Dysfunction.** Any medicine or treatment for or related to sexual dysfunction.
- (69) **Sleep disorders.** Care and treatment for sleep disorders, unless deemed Medically Necessary.
- (70) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
- (71) **Spinal Manipulation/Chiropractic services.** Covered charges are payable for services rendered by a licensed M.D., D.O. or D.C.
- (72) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (73) **Surrogate parenting.** Care, supplies, services and treatment for surrogate parenting.
- (74) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (75) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (76) **War.** Any loss that is due to a declared or undeclared act of war; provided, however, that this exclusion shall not apply to any Covered Person who is not a member of the armed forces.

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