Your Health Care Benefit Program



The Access to Care and Treatment (ACT) Plan

The Access to Care and Treatment (ACT) Plan serves as a baseline for the minimum scope of benefits that most health plans sold in the individual and small group markets must cover at equal or greater value.
Since the inception of the ACA, federal guidance has allowed each state the opportunity to select from 10 base-benchmark plans:

- The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market;
- Any of the largest three state employee health benefit plan options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment;
- The Health Maintenance Organization (HMO) plan with the largest insured commercial non-Medicaid enrollment in the state.

Absent a selection by the state, the largest small-group plan has served as the benchmark plan in the past.

For Plan Year 2020, the Centers for Medicare & Medicaid Services (CMS) is giving states greater flexibility in selecting a benchmark plan by providing three **new**, additional options. Illinois can:

- **OPTION 1:** Select an EHB-benchmark plan that another state used for the 2017 plan year;
- **OPTION 2:** Replace one or more categories of EHBs under it EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from another state's EHB-benchmark plan for 2017; OR
- **OPTION 3: Select a set of benefits that would become the benchmark plan for Illinois subject to federal guidelines.**

The Illinois Department of Insurance (IDOI) used this opportunity to explore how it could enhance the current benchmark plan benefits. The IDOI is utilizing Option 3 above and has selected the following set of benefits as the Illinois benchmark plan, subject to Federal guidelines.

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DEFINITIONS SECTION

Throughout this selection of benefits benchmark plan, many words are used which have a specific meaning when applied to health care coverage. These terms will always begin with a capital letter. When you come across these terms, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply.

ADVANCED PRACTICE NURSE.....means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

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ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA investigational new drug application.

AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorder.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(iv) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(v) is a graduate of an advanced practice nursing program.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse;

and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CIVIL UNION.....means a legal relationship between two persons, of either the same or opposite sex,

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders, Congenital or Genetic Disorders may also include, but are not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under this Certificate begins.

COVERED SERVICE.....means a service or supply specified in this Certificate for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health benefit plan under section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another domestic partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

EARLY ACQUIRED DISORDER.....means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorder as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMERGENCY SERVICES.....means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

HABILITATIVE SERVICES....means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder, including but not limited to health care services that help a person keep, learn, or improve skills and functioning for daily living.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY..... Medically Necessary means that a specific medical, health care, supply or Hospital service is required, for the treatment or management of a medical symptom or condition and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

"Serious Mental Illness".....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

(iii) Bipolar disorders (hypomanic, manic, depressive and mixed);

(iv) Major depressive disorders (single episode or recurrent);

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder;

(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(xi) Anorexia nervosa and bulimia nervosa.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function.

SUBSTANCE USE DISORDER.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc.

PHYSICIAN BENEFITS SECTION

This section of your Certificate tells you what services are covered. The benefits of this section are subject to all the terms and conditions of your Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of your Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.
For benefits to be available, under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.
Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.
2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective)

Additional Surgical Opinion
Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge after you have met your program deductible. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care
Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Substance Use Disorder Treatment Facility, or a Skilled Nursing Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or a Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home or
4. you utilize telepsychiatry care (care may be provided by either a prescriber or licensed therapist).

Consultations
Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education
Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy
Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy
Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis.

Radiation Therapy Treatments

Electroconvulsive Therapy

Speech Therapy
Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Breast Cancer Pain Medication and Therapy — Benefits will be provided for all Medically Necessary pain medication and therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer under the Prescription Drug section of this policy.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described in your Certificate. Benefits for mammograms, other than routine, should be provided at the same payment level as Outpatient Diagnostic Service.

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females.

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration.

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males.

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Investigational Treatment—Benefits will be provided for routine patient care in conjunction with investigational treatments when medically appropriate and you have a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an Approved Clinical Trial program.
Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment

of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 25 visits per benefit period.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

Routine Pediatric Hearing Examination—Benefits will be provided for routine hearing examinations.

Pulmonary Rehabilitation Therapy – Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Emergency Care

Benefits for Emergency Accident Care will be provided at the Emergency Accident Care payment level specified in the Benefit Highlights of your Certificate when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

Benefits for Emergency Medical Care will be provided at the Emergency Medical Care payment level specified in the Benefit Highlights of your Certificate when rendered by either a Participating or Non-Participating Provider after you have met your program deductible. However, Covered Services for Emergency Medical Care for the examination and testing of a victim of a criminal sexual assault or abuse

to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, should be paid at 100% of the Maximum Allowance, if specified in your Certificate.

HOSPITAL BENEFIT SECTION

This section of your Certificate tells you what Hospital services are covered.

The benefits of this section are subject to all the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, Board and General Nursing Care when you are in:
   - — a semi-private room
   - — a private room
   - — an intensive care unit
2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Urgent Care
8. Emergency Accident Care
9. Emergency Medical Care
10. Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.

11. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
12. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
13. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
14. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
15. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

OTHER COVERED SERVICES

This section describes "Other Covered Services" and the benefits that will be provided for them.

- S The processing, transporting, storing, handling and administration of blood and blood components.
- S Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- S Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- S Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- S Oxygen and its administration
- S Medical and surgical dressings, supplies, casts and splints
- S Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per benefit period.
- S Hearing Aids—Benefits will be provided bone anchored hearing aids.
- S Hearing Aids—Benefits will be provided for hearing aids for children limited to two every 36 months.

SPECIAL CONDITIONS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

Preventive Care Services

In addition to the benefits otherwise provided for in your Certificate, (and notwithstanding anything in your Certificate to the contrary), the following benefits for preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

___S evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);

___S immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;

___S evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and

___S with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this preventive care services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

Preventive Care Services for Adults:

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50
7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - _ Hepatitis A
    - _ Hepatitis B
    - _ Herpes Zoster
    - _ Human papillomavirus
    - _ Influenza (Flu shot)
    - _ Measles, Mumps, Rubella
    - _ Meningococcal
    - _ Pneumococcal
    - _ Tetanus, Diphtheria, Pertussis
    - _ Varicella
12. Obesity screening and counseling
13. Sexually transmitted infections (STI) prevention
14. Tobacco use screening and cessation interventions for tobacco users
15. Syphilis screening for adults at higher risk

Preventive Care Services for Women (including pregnant women):

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract screening or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
6. Cervical cancer screening for sexually active women
7. Chlamydia infection screening for younger women and women at higher risk
8. Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
9. Domestic and interpersonal violence screening and counseling for all women
10. Folic acid supplements for women who may become pregnant
11. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. Gonorrhea screening for all women at higher risk
13. Hepatitis B screening for pregnant women at their first prenatal visit
14. HIV screening and counseling for sexually active women

15. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
16. Osteoporosis screening for women over age 60, depending on risk factors
17. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
18. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
19. Sexually transmitted infections (STI) counseling for sexually active women
20. Syphilis screening for all pregnant women or other women at increased risk
21. Well woman visits to obtain recommended preventive services
22. Mammography for women at least every year for women ages 40 and over or at the age and intervals considered medically necessary by their Physician.

Preventive Care Services for Children:
1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Depression screening for adolescents
7. Development screening for children under age 3, and surveillance throughout childhood
8. Dyslipidemia screening for children at higher risk of lipid disorder
9. Fluoride chemoprevention supplements for children without fluoride in their water source
10. Gonorrhea preventive medication for the eyes of all newborns
11. Hearing screening for all newborns
12. Height, weight and body mass index measurements
13. Hematocrit or hemoglobin screening
14. Hemoglobinopathies or sickle cell screening for all newborns
15. HIV screening for adolescents at higher risk
16. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - _ Hepatitis A
    - _ Hepatitis B
    - _ Human papillomavirus
    - _ Influenza (Flu shot)
    - _ Measles, Mumps, Rubella
    - _ Meningococcal
    - _ Pneumococcal
    - _ Tetanus, Diphtheria, Pertussis
    - _ Varicella
    - _ Haemophilus influenzae type b
    - _ Rotavirus
    - _ Inactivated Poliovirus
    - _ any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
17. Iron supplements for children ages 6 to 12 months at risk for anemia
18. Lead screening for children at risk for exposure
19. Medical history for all children throughout development
20. Obesity screening and counseling
21. Oral health risk assessment for younger children up to ten years old

22. Phenylketonuria (PKU) screening for newborns
23. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
24. Tuberculin testing for children at higher risk of tuberculosis
25. Vision screening for all children
26. Autism screening provided without regard to the Covered Person's age

SKILLED NURSING FACILITY CARE
The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

AMBULATORY SURGICAL FACILITY
Benefits for all the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT
Benefits for all the Covered Services described in your Certificate are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center.

DETOXIFICATION
Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this Certificate, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES
Benefits for all the Covered Services described in your Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder, including behavioral health treatment. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license.

OPIOID USE DISORDER
Benefits for Buprenorphine products or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder shall not include prior authorization, dispensing limits, fail first policies, or lifetime limit requirements.

BARIATRIC SURGERY
Benefits for Covered Services received for Bariatric Surgery will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this Certificate, the same as for any other condition.

AUTISM SPECTRUM DISORDER(S)
Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition and will be provided without regard to the Covered Person's age. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is medically necessary, or, (b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be medically necessary and ordered by a Physician or a Psychologist:

- S psychiatric care, including diagnostic services;
- S psychological assessments and treatments;
- S habilitative or rehabilitative treatments;
- S therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

HABILITATIVE SERVICES
Your benefits for Habilitative Services for persons with a Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all the following conditions are met:

1. A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
2. Treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and
3. Treatment must be Medically Necessary and therapeutic and not Investigational.

MATERNITY SERVICE
Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, benefits shall be effective from the date of the birth.

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.
Benefits for treatments that include oocyte retrievals will be provided only when:

- You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and
- You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals that are eligible for coverage under this Certificate in your lifetime is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

SPECIAL LIMITATIONS

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all the Covered Services previously described in your Certificate are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

ROUTINE MAMMOGRAMS

Benefits will be provided for routine mammograms for all women. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. Benefits for routine mammograms will be provided as follows:

— one baseline mammogram

— an annual mammogram

Benefits for routine mammograms will be provided for women who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at least every year for women ages 40 and over or at the age and intervals considered medically necessary by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening of an entire breast or breasts, when determined to be medically necessary by your Physician.

Benefit Maximum

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific

evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and

4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under your Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

PEDIATRIC VISION COVERAGE

Coverage for *Pediatric Vision Care* is made part of, and is in addition to any information you may have in your Certificate. Coverage for *Pediatric Vision Care* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical health care plan. **(Services that are covered under your medical/surgical Certificate are not covered under this *Pediatric Vision Care benefit*.) All provisions in the medical Certificate apply to coverage for *Pediatric Vision Care* unless specifically indicated otherwise below.**

Definitions

Benefit Period – For purposes of *Pediatric Vision Care,* a period of time that begins on the later of:

1) the member's effective date of coverage, or
2) the last date a vision examination was performed on the member or that Vision Materials were provided to the member, whichever is applicable. (A benefit period does not coincide with a calendar year and may differ for each covered member of a group or family.)

Pediatric Frame Collection – A collection of frames that are covered under the Pediatric Vision Care benefit which includes adult sizes for members up to age 19.

Provider – For purposes of *Pediatric Vision Care,* a licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician.

Vision Materials – Corrective lenses and/or frames or contact lenses.

Eligibility

Children who are covered under a medical/surgical plan, through age 19, are eligible for coverage for *Pediatric Vision Care.* NOTE: Once coverage is lost under the medical/surgical plan, all benefits cease for *Pediatric Vision Care.* Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available for *Pediatric Vision Care.*

Limitations and Exclusions

In addition to the general limitations and exclusions listed in your medical/surgical certificate, *Pediatric Vision Care* does not cover services or materials connected with or charges arising from:

Any vision service, treatment or materials not specifically listed as a covered service;

Services and materials that are experimental or investigational;

Services or materials which are rendered prior to your effective date;

Services and materials incurred after the termination date of your coverage unless otherwise indicated;

Services and materials not meeting accepted standards of optometric practice;

Services and materials resulting from your failure to comply with professionally prescribed treatment;

Telephone consultations;

Any charges for failure to keep a scheduled appointment;

Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

Services or materials provided as a result of intentionally self-inflicted injury or illness;

Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;

Office infection control charges;

Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;

State or territorial taxes on vision services performed;

Medical treatment of eye disease or injury;

Visual therapy;

Special lens designs or coatings other than those described in this brochure;

Replacement of lost/stolen eyewear;

Non-prescription (Plano) lenses;

Two pairs of eyeglasses in lieu of bifocals;

Services not performed by licensed personnel;

Prosthetic devices and services (*prosthetic devices and services are covered as a medical benefit and may be found in the PHYSICIAN BENEFIT SECTION of this Certificate)*;

Insurance of contact lenses;

Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.
Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.
The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Certificate.

Benefit Payment for Hospice Care Program Services
Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM
BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This Benefit Section of your Certificate explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

The benefits of this section are subject to all the terms and conditions of your Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

NOTE: The use of an adjective such as Participating or Specialty in modifying a Pharmacy shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Pharmacy. In addition, the omission, non-use or non-designation of Participating or any similar modifier or the use of a term such as Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Pharmacy.

For purposes of this Benefit Section only, the following definitions shall apply:

AVERAGE WHOLESALE PRICE.....means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

BRAND NAME DRUG.....means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic to Formulary or Non-Formulary Brand Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Formulary or Non-Formulary Brand Name.

COINSURANCE AMOUNT.....means the percentage amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

COMPOUND DRUGS.....means those drugs or inert ingredients that have been measured and mixed with United States Food and Drug Administration (FDA)-approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form.

COPAYMENT AMOUNT.....means the dollar amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

COVERED DRUGS.....means any Legend Drug (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration):

(i) Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient;

(ii) For which a written or verbal Prescription Order is provided by a Health Care Practitioner;

(iii) For which a separate charge is customarily made;

(iv) Which is not entirely consumed or administered at the time and place that the Prescription Order is written;

(v) For which the FDA has given approval for at least one indication; and

(vi) Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this Benefit Section).

FORMULARY BRAND NAME DRUG.....means a brand name prescription drug product that is identified on the *Formulary Drug List* and is subject to the Formulary Brand Name Drug payment level.

GENERIC DRUG.....means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired.

LEGEND DRUGS.....means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

MAINTENANCE DRUGS.....means drugs prescribed for chronic conditions and are taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

NATIONAL DRUG CODE (NDC).....means a national classification system for the identification of drugs.

NON-FORMULARY BRAND NAME DRUG.....means a Brand Name Drug which does not appear on the *Formulary Drug List* and is subject to the Non-Formulary Brand Name Drug payment level.

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

PRESCRIPTION ORDER.....means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Orders written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this Benefit Section.

SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, you should contact your Pharmacy.

ABOUT YOUR BENEFITS

Formulary Drug List

Formulary drugs are regulated by the FDA, selected and displayed per your certificate. Some of the factors evaluated when certificate's select the formulary drugs include each drug's safety, effectiveness, cost and how it compares with drugs currently on the formulary.

Most certificates consider drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to this list can be made from time to time.

The Formulary Drug List included is an example list of drugs in each category and class. Issuer plans are required to include at least the same number of drugs in each category and class as represented in the Formulary Drug List.

Prior Authorization/Step Therapy Requirement
When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, and more serious forms of anemia, hypertension, epilepsy, and psoriasis are prescribed, your Physician may be required to obtain authorization for your medication to be eligible for benefits under your Certificate. Medications included in this program are subject to change and other medications for other conditions may be added to the program. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

Dispensing Limits
If a Prescription Order that is not an opioid prescription, is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Short-term opioid prescriptions for acute pain will be provided for no more than 7 days. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

COVERED SERVICES

Benefits for Medically Necessary Covered Drugs prescribed to treat you for a chronic, disabling, or life-threatening illness are available if the drug:

1. Has been approved by the FDA for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed:
    a. a prescription drug reference compendium approved by the Department of Insurance, or
    b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded in this Benefit Section, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names.

Injectable Drugs
Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

Immunosuppressant Drugs
Benefits are available for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Fertility Drugs
Benefits are available for Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of infertility with a written prescription.

Diabetic Supplies for Treatment of Diabetes
Benefits are available for Medically Necessary items of diabetic supplies for which a Health Care Practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:

- x Test strips specified for use with a corresponding blood glucose
- monitor S Glucose test solutions
- S Glucagon
- S Glucose tablets
- x Lancets and lancet devices
- x Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- x Insulin and insulin analog preparations

- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

Vaccinations
Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received in compliance with your certificate.

Self-Administered Cancer Medications
Benefits will be provided for self-administered cancer medications, including pain medication.

Breast Cancer Pain Medication and Therapy — Benefits will be provided for all Medically Necessary pain medication related to the treatment of breast cancer. Benefits will also be provided for all Medically Necessary pain therapy related to the treatment of breast cancer under the PHYSICIAN BENEFIT SECTION of this policy.

Cancer Medications
Benefits will be provided for orally administered cancer medications, intravenously administered cancer medications or injected cancer medications that are used to kill or slow the growth of cancerous cells. Your Copayment Amount or Coinsurance Amount or deductible will not apply to orally administered cancer medications.

Opioids
Benefits will be provided for at least one intranasal opioid reversal agent prescription for initial prescriptions of opioids with dosages of 50 MME or higher.

Acute and Chronic Pain
Benefits will be provided for topical anti-inflammatory medication including, but not limited to, Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain.

PRESCRIPTION DRUG EXCLUSIONS

For purposes of this Benefit Section only, the following exclusions shall apply:

1. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels,); and drugs or covered devices for which no valid Prescription Order is obtained.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, male contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
5. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
8. Drugs which are repackaged by a company other than the original manufacturer.
9. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
10. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except for the treatment of certain types of cancer when a particular legend drug has been shown to be effective for the treatment of that specific type of cancer even though that legend drug has not been approved for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the Federal Secretary of Health and Human Services.
11. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
12. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
13. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, or not Medically Necessary.
14. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
15. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.

16. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
17. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
18. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength.
19. Athletic performance enhancement drugs.
20. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form, except when used to treat Medically Necessary Covered Services resulting from an organic disease or illness, injury or congenital defect.
21. Some equivalent drugs manufactured under multiple brand names. XXXXXXXXXX may limit benefits to only one of the brand equivalents available. Compound Drugs
22. Medications in depot or long acting formulations that are intended for use longer than the covered days' supply amount.

ALL OTHER EXCLUSIONS—WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, or health care services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not Medically Necessary as defined by this Certificate.

— Services or supplies that are not specifically mentioned in this Certificate.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this Certificate for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under your Certificate if not provided in connection with a qualified clinical cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, specialized equipment, appliances, ambulatory apparatus, except as specifically mentioned in this Certificate.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except for Pediatric Vision and as specifically mentioned in this Certificate.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes.

— Immunizations, unless otherwise specified in this Certificate.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s).

— Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services, except as they relate to Autism Spectrum Disorder(s).

— Hearing aids, except for hearing aids for children or bone anchored hearing aids (osseointegrated auditory implants), examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.

— Diagnostic Service as part of premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.

— Residential Treatment Centers, except for Inpatient Substance Use Disorder Rehabilitation Treatment or Inpatient Mental Illness and as specifically mentioned under this Certificate

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Wigs (also referred to as cranial prostheses), unless otherwise specified in this Certificate.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.

— Abortions, including related services and supplies, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or

incest.

— Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.

— Acupuncture, whether for medical or anesthesia purposes.

*****Stand-alone pediatric dental remains identical to prior years' submissions, titled "DentaQuest of Illinois, LLC" (aka AllKids Pediatric Dental)*****