HDHP SCHEDULE OF COVERED EXPENSES AND PROVISIONS

I. Medical Deductibles, Out of Pocket Maximums and Cost Containment Penalties

<table>
<tr><th colspan="4">HDHP Plan</th></tr>
<tr><th><u>BENEFITS and PROVISIONS</u></th><th>IN NETWORK TIER 1</th><th>IN NETWORK TIER 2</th><th>OUT OF NETWORK</th></tr>
<tr><td rowspan="2">Calendar Year Deductible <u>(Combined, for all medical and prescription drug expenses, unless specifically waived)</u>
<u>Note</u>:
• Any combination of family members' expenses may contribute toward the Family Deductible for that Calendar Year.
• The Family Deductible does not have to be met for a single individual to satisfy their annual Deductible.</td><td colspan="2">Individual = $2,600
Family = $5,000*</td><td>Individual = $5,000
Family = $10,000*</td></tr>
<tr><td colspan="3">Note that In and Out of Network Deductibles are separately tracked.</td></tr>
<tr><td>Deductible Carry-Over</td><td colspan="3">N/A</td></tr>
<tr><td rowspan="2">Out-of-Pocket Maximum per Calendar Year (Co-Pays, co-insurance and deductibles count towards the Out-of-Pocket Maximum) After amount is reached, 100% level of benefits applies for that Calendar Year.

<u>In-Network and Out-of-Network maximums are separately tracked</u>.

Note that amounts you pay under the Prescription Drug Card or Mail Order Drug Programs apply to the combined medical/prescription drug Out of Pocket Maximum. However, exceptions shown at right do not apply to and are not affected by this provision.</td><td>$5,000 per Individual
$10,000 per Family</td><td>$5,000 per Individual
$10,000 per Family</td><td>$9,000 per Individual
$18,000 per Family</td></tr>
<tr><td colspan="3"><u>Medical Expenses Not Included</u> under this provision are as follows:
• Non-Compliance Penalty
• Non-covered charges, charges in excess of any Plan maximum or limit, charges in excess of U&C charges for out of network providers.</td></tr>
<tr><td>Benefits subject to a $200 “Non-Compliance Penalty” per occurrence (after Deductible) when pre-certification procedures are not followed in regard to Inpatient Hospital admissions</td><td colspan="3">TO PRE-CERTIFY, CALL THE
TOLL-FREE NUMBER
ON YOUR ID CARD</td></tr>
<tr><td>Annual Benefit Maximum</td><td colspan="3">Unlimited</td></tr>
<tr><td>Claims Filing Limit</td><td colspan="3">All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.</td></tr>
<tr><td>Coordination of Benefits</td><td colspan="3">If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (carve out). This Plan will only pay the difference of what the Plan would have paid if it was the Primary Payer.</td></tr>
</table>

II. Prescription Drugs (utilizing Plan's contracted pharmacy vendor for retail/mail order drugs)

<table>
<tr><th colspan="3">HDHP Plan</th></tr>
<tr><th><u>BENEFITS and PROVISIONS</u></th><th>IN NETWORK</th><th>OUT OF NETWORK</th></tr>
<tr><td>Separate Retail Prescription Deductible per Calendar Year</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Prescription Drug Card Program up to 30-day supply through participating pharmacies.
Note: Non-preferred Brand drugs are not covered under this Plan.</td><td colspan="2">• $15 co-pay per Generic prescription after Deductible,
• $35 co-pay per Brand prescription after Deductible
• $75 co-pay per Specialty prescription after Deductible
Once the Out-of-Pocket Maximum has been met, the Plan will pay 100% for covered prescription drugs for the remainder of the Calendar Year.</td></tr>
<tr><td>Mail Order Drug Benefit up to 90-day supply per prescription.
Note: Non-preferred Brand drugs are not covered under this Plan.</td><td colspan="2">• $35 co-pay per Generic prescription after Deductible
• $85 co-pay per Brand prescription after Deductible
Once the Out-of-Pocket Maximum has been met, the Plan will pay 100% for covered prescription drugs for the remainder of the Calendar Year.</td></tr>
<tr><td>Limitation on filling maintenance drugs at a retail pharmacy</td><td colspan="2">A maximum of 3 fills are allowed at retail for a new maintenance drug. After that, the drug must be filled through mail order only.</td></tr>
<tr><td>Specialty Pharmacy up to 30 day supply</td><td colspan="2">Provides injectable and other specialty medications to members with free delivery to patient's home or physician's office. Retail co-pay applies.</td></tr>
<tr><td>Brand when generic is available</td><td colspan="2">Patient must pay the cost difference between the brand and generic drug in addition to your co-pay or co-insurance</td></tr>
<tr><td>Prior Authorizations</td><td colspan="2">Patient may call the pharmacy benefit manager with questions regarding quantity limitations or prior authorizations</td></tr>
</table>

Contraception and contraceptive counseling - The Butler Health Plan includes coverage for several types of contraceptives. Generic hormonal and emergency oral contraceptives, diaphragms and the Mirena IUD will be covered, up to age 50, at no cost to you as the plan participant. Brand name contraceptives will remain covered, up to age 50, but you will be responsible for the standard copay. For additional information about your contraceptive benefits, including the applicable copay for a medication, please contact Express Scripts toll free at 1-866-275-0044 or online at www.express-scripts.com.

III. Wellness Care

HDHP Plan		
BENEFITS and PROVISIONS	**IN NETWORK**	**OUT OF NETWORK**
The Preventive Care Services benefit listed below, covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) That Have Been Adopted by the Director of the Centers for Disease Control and Prevention and appear on the immunization schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Womens' Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.		
Preventive Care Services (*must be billed with a routine diagnosis)* This plan includes coverage for physical exams, immunizations, tests, x-rays, pap smears and analysis, mammograms (age 40 and older, one per person per Calendar Year), PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years) and sigmoidoscopies/colonoscopies (age 50 and older, every 5 Calendar Years, but not both). This benefit specifically does not cover heart scans, full body scans, Executive Physicals, CAT scans, MRI's, PET or other similar tests)	100% Deductible Waived	50% After the Deductible
Routine Vision Exam *(one exam paid every 24 months)* *Note routine visions exams from birth to age 5 are payable under the "Preventive Care Services" benefit above.*	100% Deductible Waived	Paid same as In-Network
Breast Pumps and Supplies (Includes breast pumps and supplies purchased through a retail supplier). *Limited to a maximum payment of $450 (includes pump and supplies) per person per pregnancy.*	100% Deductible Waived	100% Deductible Waived
Family Planning - Permanent Procedures for Women *Includes:* • *Sterilization.*	100% Deductible Waived	50% After the Deductible
Family Planning – Temporary Procedures *Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.*	100% Deductible Waived	50% After the Deductible
School Flu Shots and Health Screenings *(provided at school site wellness events for covered employees and spouses)*	100% Deductible Waived	100% Deductible Waived

IV. Physician Services

HDHP Plan		
BENEFITS and PROVISIONS	**IN NETWORK**	**OUT OF NETWORK**
Primary Care Medically Necessary Physician Office Visit (*Exam charge only*)	80%	50%
Outpatient *(including office and independent laboratories)* **Diagnostic Testing and Interpretation** *(including X-rays and laboratory services, MRI, CAT and PET scan services, and other generally accepted diagnostic tests).*	80%	50%
	Includes tests and interpretation when performed in the absence of symptoms, but due to documented family history of disease (with "family" meaning parents, grandparents and siblings)	
Physician Charges for Surgery *regardless of where performed.*	80%	50%

IV. Physician Services

HDHP Plan		
BENEFITS and PROVISIONS	**IN NETWORK**	**OUT OF NETWORK**
Nutritional Counseling (up to 3 visits are covered when prescribed by your physician and a medical condition exists)	80%	50%
Second Surgical Opinion *(not required). Includes associated lab tests and x-rays.*	80%	50%
Physical, Speech, Occupational, Biofeedback and Inversion Therapy *(maximum of 20 visits per Calendar Year per each therapy type, without medical certification as to the need for additional visits).* Specific conditions apply.	80%	50%
Other Therapy Services *(dialysis, radiation, chemotherapy and respiratory therapy)*	80%	50%
Chiropractic Services *(maximum of 24 visits per Participant per Calendar Year).*	80%	50%
Urgent Care Facility Services *(professional and facility services provided; this includes non-routine care by Student Health Facilities)*	80%	80%
Other Physician Services *(except as may be stated differently in the Plan Document)*	80%	50%

V. Facility Services

HDHP Plan			
BENEFITS and PROVISIONS	**IN NETWORK Tier 1**	**IN NETWORK Tier 2**	**OUT OF NETWORK**
Inpatient Hospital Services • *Room and board not to exceed the semi-private room rate unless when required due to Medically Necessary isolation purposes, and* • *Necessary services and supplies including, but not limited to intensive care unit and a cardiac care unit* • *Admissions through the Emergency Room for Tier 2 providers will be payable at the Tier 1 level.*	80%	$300 co-pay, then paid at 80%	50%
Outpatient Surgical Center Services and Ambulatory Surgical Facility *(Including Birthing Centers)*	80%	$300 co-pay, then paid at 80%	50%
Emergency Room Services (professional and facility services provided)	80% after In-network Deductible		
Routine Outpatient Facility Diagnostic Testing (*limited to X-rays and Lab Tests)*	100% Deductible Waived	100% Deductible Waived	50%
Outpatient Facility Diagnostic Testing *for MRI, CAT and PET scan services, and other generally accepted diagnostic tests)*	80%	80%	50%
Other Outpatient Facility Services	80%	80%	50%
Home Health Care when provided by a licensed home health care agency in accordance with a written treatment plan prepared by the patient's attending Physician. 60 day limit per Calendar Year.	80%	80%	50%

V. Facility Services

HDHP Plan			
BENEFITS and PROVISIONS	**IN NETWORK Tier 1**	**IN NETWORK Tier 2**	**OUT OF NETWORK**
Hospice Care *(appropriate Inpatient and Outpatient services applicable when the patient is not expected to live more than six months)*	80%	80%	Paid at In-Network Level
Extended Care Facility (also known as Skilled Nursing Facility) – *Includes:* ▪ *room, board and floor nursing care (up to the facility's semi-private room rate)* ▪ *physical, occupational or speech therapy* ▪ *drugs, biologicals, supplies, appliances and equipment for use in the facility ordinarily furnished by the facility for the care and treatment of in-patients*	80%	80%	50%

VI. Mental Health Services

HDHP Plan			
BENEFITS and PROVISIONS	**IN NETWORK Tier 1**	**IN NETWORK Tier 2**	**OUT OF NETWORK**
Mental Health Services (Mental/Nervous, Alcohol and Drug Abuse)			
Inpatient *(Pre-certification applies)*	80%	$300 co-pay, then paid at 80%	50%
Outpatient *(note that medication management office visits will also be paid under this benefit)*	80%	80%	50%

VII. Other Services

HDHP Plan		
BENEFITS and PROVISIONS	**IN NETWORK**	**OUT OF NETWORK**
Ambulance Service *by ground or air as Medically Necessary*	80%	Paid at In-Network Level
Durable Medical Equipment *(purchase or rental- up to purchase price – of Durable Medical Equipment)*	80%	50%
Hearing Aids for routine hearing loss *(devices only; subject to a maximum payment of $500 for both ears within a 3 year replacement cycle; fittings are not covered).*	80%	50%
Smoking/Tobacco Cessation Treatment *limited to hypnosis and smoking/tobacco cessation sessions by qualified organizations. Prescription smoking cessation medications are covered under the Prescription Drug Card benefit. Not covered treatment includes gum, books, tapes, videos and mail order programs.*	50% Deductible waived	50% Deductible waived
Prosthetics *(for purchase of internal or external prosthetic appliances used to aid in the function of or to replace a limb or organ if the appliance is the original appliance or a replacement is required by pathological change or normal growth).*	80%	50%
Orthotics *(custom made when Medically Necessary – does not include corrective shoes)*	80%	50%

VII. Other Services

HDHP Plan		
BENEFITS and PROVISIONS	**IN NETWORK**	**OUT OF NETWORK**
Wigs after Chemo or Radiation therapy *(limited to a Calendar Year maximum payment of $200)*	80%	50%
Well Newborn Care (*other than as covered under the Wellness Care benefit) includes but is not limited to Nursery Care Services and Circumcision.*	80%	50%
Blood and blood products *(if not donated or replaced)*, **intravenous injections and solutions**	80%	50%
Organ Transplant Coverage *(covered transplants are listed in the Plan Document)* **Per Transplant Donor Coverage Maximum of $5,000**	80%	50%
Infertility Treatment *(any services for the promotion of conception including but not limited to: in-vitro fertilization, artificial insemination, GIFT or ZIFT, and prescription drugs related to treatment of infertility).*	Not Covered	Not Covered
Jaw Joint Treatment. Covered Services include one jaw joint appliance but will not include orthodontic related expenses even if Medically Necessary.	80%	50%
Orthopedic Equipment and Appliances	80%	50%
Maternity Services *(covered same as any Illness and includes charges for prenatal, delivery and postpartum services)*	80%	50%
Dental Related Treatment *(includes services required in connection with an accidental non-biting or chewing Injury to sound natural teeth or jaw, and performed within 6 months of the accident)*	80%	50%
Men's Voluntary Sterilization *(but not the reversal of such procedures)*	80%	50%
Cosmetic Surgery *limited to surgical charges for reconstructive surgery following mastectomy (as mandated by the Womens' Health and Cancer Rights Act) or to treat an accidental Injury or birth defect.*	80%	50%
Gastric Bypass surgery	Not Covered	Not Covered
Services provided by a non-patient selected Out of Network Physician while being treated in a Network Hospital	Not Applicable	Paid same as In-Network
Other Covered Services and Items	80% Unless included under a previous category	50% Unless included under a previous category

PRESCRIPTION DRUG BENEFIT

Prescription drug benefits are provided through the pharmacy benefit plan manager listed in the Prescription Drug Benefit section of the Schedule of Covered Expenses and Provisions. Benefits will be paid as stated in the Schedule of Covered Expenses and Provisions for charges made by a participating pharmacy for treatment of You or Your eligible Dependents Illness or Injury. A covered charge is considered made on the date the prescription is dispensed by the pharmacist.

Covered Prescription Drugs: Except for excluded items, the Plan covers drugs that, by law, may be dispensed only by prescription, and that fall within one of the following categories:

1. Federal (United States) Legend Drugs (including oral and injectable contraceptives, and contraceptive devices);
2. State restricted drugs; or
3. Compound drugs that contain at least one Prescription Legend Drug.
4. Smoking cessation: All adults over the age of 18 are eligible for generic over-the-counter and prescriptions (with a prescription from your doctor) for up to 90 days during a 365 day period. Chantix is also covered for all adults over the age of 18 for up to 180 days of treatment during a 365 day period. These will be covered at no cost to you during the eligible period. Once the benefit has been exhausted, you will not be eligible for additional coverage until the end of the 365 day period.

Covered Pharmaceutical Products: The Plan also covers insulin, diabetic testing devices, test strips, syringes, and needles.

Drugs and Pharmaceuticals Not Covered:

The Plan does not pay for any of the following medications or pharmaceutical products listed:

1. Any non-preferred Brand drugs
2. Any covered drug in excess of the quantity specified by the Physician, or any refill dispensed after 1 year from the Physician's order
3. Any device or appliance (e.g. orthotics and other non-medical substances), unless specifically listed as a covered prescription drug.
4. Diagnostic medications
5. Experimental drugs
6. Fertility Drugs
7. Fluoride Preparations
8. Gold Compounds – prepared with raw chemical ingredients, or legend drugs prepared in a non-FDA approved dosage form
9. Irrigation Solutions
10. Medications furnished on an in-patient basis covered under any other carrier providing group coverage for prescription legend drugs or insulin through Coordination of Benefits provision (e.g. major medical, home health care benefits, outpatient benefits)
11. Medical Supplies (e.g. Ostomy Supplies)
12. More than a 30-day supply of a covered Drug

13. More than a 90-day supply of a covered Maintenance Drug
14. Over-the Counter products
15. Pharmaceutical Products used for Cosmetic purposes
16. Prescription vitamins, except pre-natal
17. Serums, Toxoids, and Vaccines
18. Smoking Cessation Products (See Smoking Cessation benefit)
19. Therapeutic Devices or Appliances
20. Yohimebine

MAIL ORDER DRUG BENEFIT

This benefit offers a mail order service which delivers required prescription drugs directly to your home after a per prescription co-pay has been made (see Schedule of Covered Expenses and Provisions for co-pay amount). The mail order drug benefit permits up to a 91-day supply of medication and up to one year of refills upon authorization.

You should receive a packet providing complete details on how to use your mail order drug benefit. If you have any questions regarding this aspect of your coverage, please contact your Human Resources Department.

SPECIALTY DRUG PHARMACY BENEFIT

Certain specialty medications may be required to be purchased through your pharmacy vendor's or Allied's specialty pharmacy program. Typically, these medications are very costly, require special storage or handling, are for long term use, or require careful monitoring and management. You will be notified by the pharmacy at the time of purchase if a particular drug is in this specialty pharmacy program, or you may call the pharmacy vendor (see your member ID card) as soon as a drug has been prescribed to determine how it must be dispensed. The specialty pharmacy unit will coordinate fast shipment to the location a member chooses, such as your home or your Physician's office. Alternatively, if your pharmacy vendor indicates that they cannot dispense the drug, please contact Allied's customer service team (see your member ID card) to determine how the specialty drug that has been prescribed must be dispensed. Please refer to previous pages for coverage provisions.

TRANSPLANTS

Preferred Transplant Network Facility:

A Preferred Transplant Network Facility is a facility contracted with the Plan's Preferred Transplant Network (PTN) to furnish particular services and supplies to You or Your Dependent in connection with one or more highly specialized medical procedures. The maximum charge made by the PTN for such services and supplies will be the amount agreed to between the Plan's PTN and the PTN facility.

Transplant Expenses

Once it has been determined that you or one of your Dependents may require an ***organ*** transplant, you or your Physician should follow the guidelines listed in the Pre-Certification Program to coordinate your transplant care. You must follow any pre-certification requirements. ***Organ*** means solid organ, stem cell, bone marrow, or tissue.

While all organ transplants (other than cornea or skin transplants) are covered only under this section, benefits may vary if a PTN facility or non-PTN facility is used. The PTN facility must be specifically approved and designated by the PTN to perform the procedure you require. A transplant will be covered as in-network only if performed in a facility that has been designated as a PTN facility for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as a PTN facility, even if the facility is considered as a network facility for other types of services, will not be considered in-network. Additionally, if a PTN facility is utilized, you may be eligible for certain travel benefits related to the organ transplant.

Covered Transplant Expenses

Covered transplant expenses include the following (unless stipulated otherwise by a separate transplant agreement between the Plan, PTN, and PTN facility):

- Inpatient and Outpatient expenses directly related to a transplant.
- Charges made by a Physician or transplant team.
- Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the PTN facility during the transplant process. These services and supplies may include: physical therapy, speech therapy and occupational therapy; bio-medicals and immunosuppressants; and home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and

end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes Inpatient and Outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your Inpatient stay or Outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or Outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following organ transplants will be considered one Transplant Occurrence:

- Heart transplant.
- Lung transplant.
- Heart/lung transplant.
- Simultaneous Pancreas Kidney (SPK) transplant.
- Pancreas transplant.
- Kidney transplant.
- Liver transplant.
- Intestine transplant.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant surgery.
- Sequential transplants.
- Re-transplant of same organ type within 180 days of the first transplant.
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be more than one Transplant Occurrence:

- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Limitations

The transplant coverage does not include charges for:

- Outpatient drugs, including bio-medicals and immunosuppressants, not expressly related to an Outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a Covered Person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.
- For donor services if you or your covered Dependent are a donor.

WHAT IS NOT COVERED

Although the Plan covers charges for most Illnesses and Injuries, it does not cover charges for or in connection with:

Cosmetic Surgery

The Plan does not pay for cosmetic surgery unless provided:

1. For reconstructive purposes following mastectomy,
2. In connection with an accidental Injury, or
3. To treat a birth defect.

Dental Services

The Plan does not pay for dental treatment unless provided in connection with accidental Injuries to sound natural teeth and begun within six months after the accident.

Eye Care

The Plan does not pay for eye care for visual training, surgical treatment of visual refractive problems (such as radial keratotomy), or prescription or fitting of eyeglasses or contact lenses (except for eye examination and the first set of lenses and frames following cataract surgery).

Foot Care

The Plan does not pay for routine foot care such as:

1. Treatment of corns, fallen arches, flat feet, chronic foot strain or other symptomatic complaints of the feet, or purchase of related items such as corrective shoes, wedges, splints or pads.
2. Treatment of calluses or cutting of toenails. However, treatment will be covered for ingrown toenails, and where Medically Necessary because of diabetes or other medical conditions.
3. Treatment of bunions, except by capsular or bone surgery.

Gastric By-Pass Surgery

Surgical treatment of morbid obesity is not a covered benefit.

Government Service and Illegal Acts

The Plan does not pay for treatment of a condition or Injury resulting from or caused or prolonged by:

1. Involvement in an illegal occupation.

2. War (whether declared or undeclared), civil war, invasion, hostilities, riot, or resistance to armed aggression.
3. Duty as a member of the armed forces of any country or state.
4. Public service, where the U.S. Government or any state or local government provides the treatment.
5. Services or supplies that are in violation of any law.
6. Performance or attempted performance of an assault or felony.
7. An altercation in which you were the aggressor.

Hearing Exams

The plan does not pay for hearing examinations or examinations for prescribing and fitting hearing aids except as stated (See “Schedule of Covered Expenses”).

Incidental and Personal Convenience Items

The Plan does not pay for incidental and personal convenience items such as:

1. Telephone, television, haircuts, and newspapers while you are a Hospital inpatient.
2. Completion of claim forms.
3. Missed appointments.
4. Travel mileage or lodging.

Infertility Treatment

The Plan will not pay for the diagnosis, treatment or medications prescribed for the treatment of Infertility.

Non-Medical and Experimental Procedures

The Plan does not pay for:

1. Physical examinations, tests and reports performed for non-medical reasons, such as those for insurance, school, camp, employment, sports, governmental or legal reasons, or travel.
2. Experimental or Investigational drugs or procedures, or care, service or treatment provided under a study, grant or research program, or for research purposes.

Services or Supplies

The Plan does not pay for services and supplies:

1. That are self-administered;
2. That are provided by a member of your immediate family or by a person who normally lives with you;
3. That are provided in a medical department or clinic maintained by your Employer; or
4. For which you would not be required to pay if you didn’t have Plan coverage.

Work-Related Injury/Illness

The Plan does not cover treatment of any Illness or Injury received or developed in the course of any work for wage or profit:

1. Unless and until the claim has been submitted to, and a final decision made by, the State Bureau of Workers' Compensation, and thereafter the Plan will cover such charges only to the extent they are not allowed by Workers' Compensation, and subject to all other Plan limitations and requirements.
2. If the Bureau of Workers' Compensation denies the claim because it was not submitted to the Bureau within applicable time limits.
3. By a self-employed Plan Participant who did not obtain Workers' Compensation coverage.

Other Exclusions

The Plan does not pay for the following, even if recommended or prescribed by a Doctor:

1. Acupuncture.
2. Aromatherapy.
3. Biofeedback, except as specified covered. (See "Schedule of Covered Expenses" — "Smoking/Tobacco Cessation").
4. Care, service, treatment, or items that:
    a. Were provided before your effective date of Plan coverage or after your coverage ended;
    b. Are not Medically Necessary as initially determined by the Claim Administrator and as may be confirmed through the appeals process;
    c. Are routine services except as specified. (See— "Schedule of Covered Expenses");
    d. Are provided by any Out-of-Network Provider, to the extent the charges are more than the Usual and Customary charges as determined by the Claim Administrator; or
5. Custodial care, maintenance therapy or supportive care, including services provided primarily for pain relief.
6. Developmental speech therapy.
7. Donation of human organ, tissue, or bone marrow to a recipient who is not a Plan Participant.
8. Educational services or classes.
9. Elective abortion, except for care in connection with a spontaneous abortion or complications resulting from an abortion.
10. Enrollment in a health, athletic, or similar club.
11. Homeopathic Treatment.
12. Hospitalization for change of environment.
13. Hypnotism- (See "Schedule of Covered Expenses"—"Smoking/Tobacco Cessation.").
14. Maintenance contracts for purchased durable medical equipment.
15. Marital counseling.
16. Massages or other personal services.
17. Medical evacuation to return home when traveling outside of the continental United States.
18. Nutritional supplements.

19. Organ donation. The Plan does not pay for donation of human organ, tissue, or bone marrow to a recipient who is not a Plan Participant.
20. Postmortem expenses.
21. Private duty professional services while confined as an inpatient.
22. Purchase or rental of:
    a. Items of common or personal use such as thermometers, bandages, first aid ointments and supplies, non-allergy pillows and mattresses, air purifiers, air conditioners, water purifiers, exercise equipment, saunas, steam baths, swimming pools, and waterbeds.
    b. Motorized transportation equipment, chair lifts, escalators, or elevators, except for Medically Necessary equipment such as wheelchairs.
    c. Spare or duplicate prosthetics, orthotics, appliances, or supplies.
23. Recreational, educational, self-help, or self-care training, except for Medically Necessary, Hospital-based, nutritional counseling related to the treatment of newly-diagnosed diabetes.
24. Rest cures.
25. Reversal of sterilization procedures.
26. Seeing-eye dogs or other domestic animals providing therapy or assistance with daily living.
27. Sex change procedures.
28. Testing, treatment, or training related to learning disabilities.
29. Treatment of non-morbid obesity or enrollment in a weight loss or similar program.
30. Vitamins or minerals, unless administered by a Physician in an injectable form.
31. Provider charges claimed as a result of purported lost discounts.