Premier Health Employee Plan

Your Premier Health Employee Plan Benefits-HSA

As a Premier Health Employee Plan member, you will have access to comprehensive healthcare benefits. This guide is designed to help you understand your coverage and get the most out of your benefits. It also provides tools and resources to help you take charge of your personal health and manage healthcare expenses for you and your family. Review this summary to find out how to use your Premier Health Employee Plan benefits, and keep it handy as you access services throughout the year.

Premier Health Employee Plan Member Services: (855) 869-7139, Monday – Friday, 7 a.m. to 7 p.m. and Saturday, 8 a.m. to 3 p.m.

2017 Medical Benefits

Tier I - Premier Health Group
Tier I includes facilities, doctors, healthcare professionals and services. The majority of providers are within a nine-county local area. Except in the case of an emergency, you must use Premier Health Group providers if you receive healthcare services within one of these nine counties: Montgomery, Greene, Miami, Warren, Butler, Clark, Darke, Shelby and Preble.
Search for providers at PremierHealthyLiving.org

Tier II - Your Network if You Are Accessing Care Outside the Nine-County Area
Tier II Regional Network - SuperMed PPO
Your Tier II regional network includes doctors, facilities, other healthcare professionals, and services located:

- In the state of Ohio, but outside the nine Ohio counties in Tier I, AND
- In the state of Indiana, AND
- In the following counties in Kentucky: Boone, Kenton, Campbell, Grant, Pendleton, Gallatin, Carroll, Henry, Owen, Scott, Harrison, Robertson, Bracken, Mason, Lewis, Greenup, and Boyd

Tier II National Network - PHCS MultiPlan
Your Tier II national network includes doctors, facilities, other healthcare professionals, and services located:

- Outside the nine-county Tier I network
- Outside the Tier II regional network
- Within the United States

Search for providers at PremierHealthyLiving.org

No Coverage of Services Outside of Tier I and Tier II
With the exception of emergency care and urgent care which are subject to the Tier I deductible and co-insurance.

Benefits	Tier I (In-area) Premier Health Group	Tier II (Out-of-area) Your Network if You Are Accessing Care Outside the Nine-County Tier I Network	Non-covered Providers Out-of-Network
HSA			
Employer contribution	N/A		
Calendar Year Deductible			
Per individual	$2,500		Not covered
Per family	$5,000		Not covered
* Aggregate Deductible –The entire family deductible must be satisfied prior to coinsurance being applied. *Tier I and Tier II deductibles cross apply.			
Out-of-pocket Maximum			
Per individual	$6,550		Not covered
Per family	$13,100		Not covered
*Out-of-pocket includes deductible and coinsurance amounts, including pharmacy coinsurance amounts. *Out-of-pocket maximums for Tier I and Tier II accumulate together. Coinsurance amounts for out-of-network emergency care and urgent care also accumulate toward the out-of-pocket maximum.			Not covered
Coinsurance (Percent paid by you)			
Coinsurance is the percentage of expenses you are responsible to pay after you have met your deductible	10% coinsurance after Tier I deductible is met, unless otherwise stated	30% coinsurance after Tier II deductible is met, unless otherwise specified	Not covered
Lifetime Maximum	None	None	None
Office Visits-Physician			
Primary care visit (including retail clinics and student health facilities)	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Specialist visit	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Diagnostic Testing – Lab, x-rays, diagnostics and major diagnostics	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Surgical procedures	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Preventive Care Services			

Preventive services-as addressed in the Accountable Care Act	Paid in full, deductible does not apply	Paid in full, deductible does not apply	Not covered
Emergency Care			
Emergency room visit (for serious injury or extreme illness)	10% coinsurance after Tier I deductible is met	10% coinsurance after Tier I deductible is met	10% coinsurance after Tier I deductible is met
Non-emergency use of the emergency room	Not covered	Not covered	Not covered
Ambulance services (air and ground)	10% coinsurance after Tier I deductible is met	10% coinsurance after Tier I deductible is met	10% coinsurance after Tier I deductible is met
Urgent Care	10% coinsurance after Tier I deductible is met	10% coinsurance after Tier I deductible is met	10% coinsurance after Tier I deductible is met
Inpatient Services (*Preauthorization required for all)			
Daily room, board and general nursing care	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Skilled nursing facility	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Chemotherapy, Radiation, Dialysis, Hemodialysis, Infusion Therapy, Physical/Occupational/Speech Therapy, Respiratory Therapy	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Inpatient diagnostic x-rays and lab tests	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Inpatient surgery	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Outpatient Services			
Outpatient diagnostic – lab, x-rays, diagnostics and major diagnostics	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Outpatient surgical procedures *Preauthorization required for some services	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Outpatient Therapies			
Physical therapy, occupational therapy and speech therapy *Limit of up to 60 visits combined for Physical, Occupational and Speech therapy	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Chemotherapy and radiation therapy *Selective internal radiation therapy requires preauthorization	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered

Dialysis and hemodialysis	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Cardiac rehabilitation	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Respiratory therapy	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Maternity Care and Reproductive Health			
Maternity care – physician services	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Maternity care – facility services	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Artificial insemination	Not covered	Not covered	Not covered
In-vitro, GIFT, ZIFT	Not covered	Not covered	Not covered
Mental Health and Substance Abuse			
Inpatient and Intermediate Mental Health Services, Substance Use Disorder Services, and Neurobiological Disorders - Mental Health Services for Autism Spectrum	10% coinsurance after Tier I deductible is met	N/A	Not covered
Outpatient Mental Health Services, Substance Use Disorder Services, and Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders	10% coinsurance after Tier I deductible is met	N/A	Not covered
Home Health and Hospice			
Home health care *Private duty nursing not included	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Hospice Care	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Other Services			
Organ transplant *Preauthorization required	10% coinsurance after Tier I deductible is met	10% coinsurance after Tier I deductible is met	Not covered
Chiropractic care *Limit of 20 visits per year	50% coinsurance after Tier I deductible is met	50% coinsurance after Tier II deductible is met	Not covered
Bariatric surgery *Pre-authorization required. Limit to one procedure per lifetime with a maximum of $25,000; benefit for employee only. Three-year consecutive enrollment in the Premier medical plan required to be eligible. Must meet medical criteria. Service must be performed at Miami Valley Hospital.	10% coinsurance after Tier I deductible is met	Not covered	Not covered
Dental treatment for accident or injury	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Diabetic supplies for insulin pump *Other supplies are covered under Prescription Drug benefits	20% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered

Durable medical equipment (purchase and rental)	20% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Hearing aid services *Limited to 2 hearing aids every three years, $4,000 payable maximum	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Nutritional counseling *Subject to medical necessity *Limited to three visits per year	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Oral surgery *Covered for accidental injury only	10% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered
Prosthetics	20% coinsurance after Tier I deductible is met	30% coinsurance after Tier II deductible is met	Not covered

How to Access Your Benefit Information

As a member, you have convenient access to online services and benefits information at any time. Visit PremierHealthyLiving.org to login to MyHealth OnLine and:

- View an online directory of providers on PremierHealthPlan.org
- Review your medical history, benefits, co-payments, and eligibility
- Find your Explanation of Benefits (EOB)
- Request a new or replacement member ID card and print a temporary member ID card
- Update contact information, such as your email address or phone number
- Live chat or send a secure message to Member Services, and locate Member Services contact information
- Access health promotion resources, tools and expert health information
- Download common member forms and documents, including:
    - Out of Network Claim Form
    - Coordination of Benefits Verification Form
    - Transition of Care Application
    - Provider Nomination Form
    - Notice of Privacy Practices
    - Member Request for Confidential Communication Concerning PHI Form
    - Member Authorization to Use/Disclose PHI Form
    - Personal Representative Designation Form

Emergency Services

All members have coverage for emergency services. If emergency services are received at a non-Premier Health Group facility within the service area, when medically appropriate, you will be stabilized and transported to a Premier Health Group facility.

Emergency services are any healthcare service provided after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- 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.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency transportation provided by an ambulance service constitutes an emergency service.

Urgent Care

Urgent Care is care received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed (e.g. a high fever) and requires prompt medical attention to avoid complications and unnecessary suffering or severe pain. You should contact your treating provider within 24 hours or a reasonable time of receiving Urgent Care to arrange or obtain necessary follow-up care.

Services Excluded from Coverage through the Plan

Not all healthcare services are covered services. The following is a list of services that are not covered under the Plan. If you are not sure if a service is covered, call Member Services to find out if that service is covered under the Plan.

1. **Alternative Medicine**—Acupuncture, except as set forth in the Summary Plan Description. Acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.

2. **Behavioral Health Services:**

    - Any psychotherapy, psychiatric care, or treatment services for mental health or substance use which are court-ordered, unless such services are medically necessary.
    - Treatment for personality disorders where that is the primary diagnosis.
    - Eligibility for and maintenance of Social Security disability benefits does not determine whether the Plan will cover specific behavioral health or substance abuse treatment services. Medical necessity criteria will be used to determine whether specific treatment services are covered.
    - Any treatment/services related to personal or professional growth/development, educational or professional training or certification, or treatment services required for investigative purposes related to employment.
    - Any services necessary to obtain or maintain employment or insurance or for judicial or administrative proceedings, including, but not limited to, adjudication of marital, child support, or custody cases.
    - Methadone maintenance for the treatment of chemical dependency.
    - Treatment for chronic behavioral conditions, once you have been restored to the pre-crisis level of function.
    - Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder.
    - Chronic maintenance therapy, except in the case of serious mental illness.
    - Bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies, such as art or psychodrama or other therapy.

- Sex therapy without a diagnosis as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Sedative action electrostimulation therapy.
- Sensitivity training.
- 12-step model programs as sole therapy for conditions, including, but not limited to, eating disorders or addictive gambling.
- Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner.
- Truancy or disciplinary problems not associated with a treatable mental disorder.
- Psychoanalysis or other therapies that are not short-term or crisis-oriented.
- Psychological and neuropsychological testing for learning disabilities or problems, other school-related issues, to obtain or maintain employment, to submit a disability application for a mental or emotional condition, and any other testing that does not require administration by a behavioral health professional, including self-test reports.
- Intensive health coaching services, resource coordination activity, behavioral health rehabilitation services for children and adolescents, and summer camp programs are not covered services.
- Respite services.

3. **Blood—**Non-purchased blood or blood products, including autologous donations.
4. **Corrective Appliances—**Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan and other appliances or devices, or any related services, including, but not limited to, children's corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, shoe inserts, or orthopedic shoes, unless otherwise set forth herein.

5. **Cosmetic Surgery**—Surgical or other services for cosmetic purposes performed to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected, except as such surgery or services are required to be covered by law. Excluded services include, but are not limited to, port wine stains, augmentation procedures, reduction procedures, and scar revisions.

6. **Court Ordered**—Court-ordered services when your physician or other professional provider determines that those services are not medically necessary.

7. **Custodial Care**—Custodial care, domiciliary care, residential care, or protective and supportive care, including, but not limited to, respite care, rest cures, educational services, convalescent care, dietary services, homemaker services, maintenance therapy, and food or home-delivered meals.

8. **Dental Care**—Except as otherwise set forth in this document, services directly related to care, treatment, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth, including, but not limited to, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), and dental examinations.

9. **Vision:**

    - Eyeglasses and contact lenses (except where you have cataracts, keratoconus, or aphakia), including those for prescribing or fitting eyeglasses or contact lenses.
    - Services for the correction of myopia, hyperopia, or astigmatism, including, but not limited to, radial keratotomy.
    - Vision training for certain diagnoses.
    - Orthoptics.

10. **Employment Related or Employer Sponsored Services:**

- For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation.
- Services that you receive from a dental or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.
- Services which are experimental/investigational in nature as determined by the Claims Administrator.

11. **Experimental/Investigational**—Services that are experimental/investigational in nature as determined by the Claims Administrator.

12. **Food Supplements/Vitamins**—Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.

13. **Genetic Counseling and Testing**—Genetic counseling and testing not medically necessary for treatment of a defined medical condition, except when such coverage is required by PPACA.

14. **Growth Hormones**—Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner's syndrome, or certain other diagnoses as determined by the Claims Administrator and authorized in accordance with applicable policy and procedure.

15. **Hearing Examinations**—Hearing examinations and related services, except when such coverage is required by PPACA.

16. **Home Care**—Home care for chronic conditions such as permanent, irreversible disease, injuries, or congenital conditions requiring long periods of care or observation.

17. **Home Medical Equipment**—Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a professional provider. Medical equipment and supplies that are (a) expendable in nature (i.e., disposable items such as

incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and (b) primarily used for non-medical purposes, regardless of whether recommended by a professional provider.

18. **Infertility**—Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

19. **Immunizations and Drugs**—Physical examinations and immunizations required by foreign travel, school, or employment, except as required by PPACA.

20. **Inpatient/Outpatient Healthcare Provider Services:**

    - Medical care for inpatient stays primarily for diagnostic services or observation (observation is only covered at the observation rate).
    - Medical care for inpatient stays that are primarily for rehabilitation services, except inpatient comprehensive physical rehabilitation services.
    - A private room, when the hospital has a semi-private room available (Payment will be based on the average semi-private room rate).

21. **Medical/Dental Services not Identified as "Covered" in Summary Plan Description**—Any other medical or dental service or treatment, except as provided in the Summary Plan Description or as mandated by law.

22. **Medical Devices and Supplies**—Durable medical equipment or supplies associated or used in conjunction with non-covered items or services.

23. **Medically Unnecessary Services**—Services that are not medically necessary as determined by the Claims Administrator.

24. **Medicare**—Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary; however, this exclusion does not apply when your employer or group plan sponsor is required by law to offer you all of the benefits set forth in the Summary Plan Description and you elect this coverage as your primary coverage.

25. **Medicare Eligibility—**Any amounts that you are required to pay under the deductible and/or coinsurance provisions of Medicare or Medicare supplement coverage.

26. **Mental health and substance use disorder services,** including behavioral health treatment, that include:

    a. Marital counseling

    b. Wilderness programs

    c. Boarding schools

27. **Military Service:**

- Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you.
- Services that are provided to members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service-related illness or injury, unless you have a legal obligation to pay.

28. **Miscellaneous—**Any services, supplies, or treatments not specifically listed in the Summary Plan Description as covered benefits, services, supplies, or treatments, unless they are preventive care services.

- Services and supplies that are not provided or arranged by a participating provider and/or authorized for payment in accordance with Medical Management Department policies and process.
- Any services related to or necessitated by an excluded item or non-covered service.
- Services provided by a non-licensed practitioner or practitioner not recognized by the Plan.
- Services which are primarily educational in nature, including, but not limited to, vocational rehabilitation or recreational or educational therapy.
- Services rendered prior to the effective date of your coverage or incurred after the date of termination of your coverage, except as provided elsewhere in the Summary Plan Description.

- Services for which you otherwise would have no legal obligation to pay.
- Charges for telephone consultations.
- Charges for failure to keep a scheduled appointment.
- Concierge fees or boutique medical practice membership fees.
- Educational therapies intended to improve academic performance.
- Financial/legal services.
- Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
- Charges for completion of any insurance form or copying of medical records.
- Personal comfort items, including when used in an impatient hospital setting, including telephones, televisions, laundry charges or guest trays.
- Services rendered by a professional provider who is a member of your immediate family. Immediate family is defined as the member's spouse, child, stepchild, parent, sibling, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law, brother-in-law, or grandparent.
- Services that are submitted by two different professional providers for the same services performed on the same date for the same individual.
- Services for, or related to, any illness or injury suffered after the effective date of your coverage that is the result of any act of war.
- Vocational rehabilitation and employment counseling.

29. Motor Vehicle Accident/Workers' Compensation—Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a motor vehicle insurance policy, including,

but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law.

30. **Non-Medical Items**—Health club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a physician.

31. **Nutritional Supplements**—Blenderized food, baby food, or regular shelf food when used with an enteral system; milk- or soy-based infant formula with intact proteins; any formula, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance; oral semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; food additives, including, but not limited to, thickeners, vitamins, fiber supplements, calorie or protein supplements and lactose digestion products, and normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

32. **Oral Surgery**—Services, including or related to oral surgery, except as otherwise outlined in this document. Exclusions include, but are not limited to:

- Services that are part of an orthodontic treatment program
- Services required for correction of an occlusal defect
- Services encompassing orthognathic or prognathic surgical procedures
- Treatment of temporomandibular joint syndrome or temporomandibular joint disorders, except as set forth in the Summary Plan Description under the covered benefits section
- Removal of asymtomatic, non-impacted third molars
- Orthodontia and related services

33. **Organ and Tissue Transplants:**

- Services for or related to any organ transplant except those deemed medically necessary and non-experimental/investigational by the Plan
- Any organ transplant or procurement done outside of the continental U.S.
- An organ transplant relating to a condition arising from employment
- Organ and tissue transplant covered services, if there are research funds available to pay for the services
- Expenses incurred while searching for a suitable donor

34. Over-The-Counter Drugs—Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise outlined in this document.

35. Physical Examinations—Physical examinations, immunizations, or behavioral health services obtained for the completion of forms and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive or medically necessary purposes, including, but not limited to, premarital examinations, physicals for employment, school, camp, and participation in sports or travel except as otherwise outlined in this document or when such coverage is required by PPACA.

36. Podiatry Services—Palliative or cosmetic foot care, including, but not limited to:

- Treatment of weak, strained, flat, unstable, or unbalanced feet
- Metatarsalgia or bunions (except open cutting procedures)
- Treatment of corns, calluses, or toenails (except removal of nail roots if determined to be medically necessary by the Claims Administrator). Supportive orthotic devices for the foot are excluded unless you have diabetes or peripheral vascular disease.

37. Rehabilitative Therapy—Rehabilitative therapy services, including, but not limited to, physical therapy, occupational therapy, and speech therapy provided to correct or alleviate developmental delay, school-related problems, apraxic disorders (not caused by accident or episodic illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders. Physical, occupational, and

speech rehabilitation therapy services provided in excess of the maximum number of visits per benefit period, as indicated in the schedule of benefits; cardiac rehabilitation services provided in excess of 12 weeks; pulmonary rehabilitation services provided in excess of 24 visits per benefit period; rehabilitation therapy services not expected to result in ongoing substantial improvement in your medical condition; and services provided after a maintenance level has been established.

38. **Reversal of Voluntary Sterilization Procedures**—Services to reverse sterilization.

39. **Surrogate Motherhood**—Services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to conception, prenatal care, delivery, and postnatal care of a member acting as a surrogate mother.

40. **Temporomandibular Joint Syndrome**—Treatment of temporomandibular joint syndrome or temporomandibular joint disorders, regardless of the nature of the problem, except as set forth in the Summary Plan Description.

41. **Transportation**—Non-emergent transportation, by any means, including via ambulance provider, unless such transportation is Prior Authorized by the Medical Management Department.

42. **Treatment Outside the U.S.**—Treatment for non-emergent or non-urgent services received outside the U.S.

43. **Weight Reduction**—Weight reduction programs, including all related diagnostic testing and other services, except as outlined in this document for morbid obesity or when coverage is required by PPACA. Antiobesity medication, including, but not limited to, appetite suppressants and lipase inhibitors, but you should check with your pharmacy benefit plan to see if these medications are covered.