IT'S ABOUT *you!*

Bath&BodyWorks®

2025 SAN FRANCISCO MEDICAL PLAN SUMMARY

This summary provides details about your 2025 San Francisco Medical Plan options offered through Anthem to eligible Bath & Body Works associates in San Francisco.

For details about your other benefits, see the 2025 Benefits Book for Full-Time associates posted on **mybbwbenefits.com.**

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Medical

Medical 2025 Biweekly Contributions

Here's what you'll pay for medical coverage, pre-tax, biweekly if you cover your children in the San Francisco medical plan. Associates are offered coverage at no cost.

Note: *Information on the Anthem Lower, Lower Deductible and In-Network Only medical plans for benefits-eligible associates can be found in the Health Benefits Book for Full-Time Associates on* ***mybbwbenefits.com****.*

	San Francisco Medical Plan	Lower Premium	Lower Deductible	In-Network Only
Associate Only	No Cost	$42.97	$72.81	$112.26
Associate + Spouse/ Domestic Partner	N/A	$117.32	$199.74	$307.46
Associate + Child(ren)	$82.39	$97.60	$165.85	$255.87
Associate + Family	N/A	$140.08	$237.66	$366.09

Check if Your Doctor is In the Anthem Network

- Go to **anthem.com**
- Click on Find a Doctor
- Enter as a member or guest
- Answer a few questions—your plan name is Anthem National PPO (BlueCard PPO)
- Confirm your doctor is in the network

Note: If your doctor is not in the network, there is no coverage under the In-Network Only plan.

LiveHealth Online Telehealth

"FaceTime" with a doctor live with Anthem's LiveHealth Online through your computer, tablet or smartphone. It will save you time and money when you do! It's available real-time, 24/7/365 in most states. With LiveHealth Online:

- Doctors are in-network, U.S. board-certified and can ePrescribe to local pharmacies (where applicable)
- Lower Deductible and In-Network Only Plans: $15 Co-Pay (Visa, MasterCard and Discover)
- Lower Premium Plan: $49 applied to Deductible, once Deductible is met, 20% Coinsurance applies

To access LiveHealth Online, go to **livehealthonline.com**.

Know Your Terms

Here are some important terms to know as you decide the medical plan to choose, as well as how to use it during the year:

- **CO-PAY** A flat fee for medical service. Your co-pays will count toward your out-of-pocket maximum.
- **DEDUCTIBLE** The amount you pay up front for covered medical services before coinsurance kicks in and then you're done with the deductible for the year. Your deductible will count toward your out-of-pocket maximum.
- **COINSURANCE** The percentage you pay for covered medical services once your deductible is paid – and then Bath & Body Works pays the balance.
- **OUT-OF-POCKET MAXIMUM** The most you'll pay for covered medical services in a plan year, so you're protected from high-cost claims. Once your share of medical expenses reaches the maximum, Bath & Body Works will pay 100% of your covered services for the balance of the year. These apply to your out-of-pocket maximum: Co-pays, deductibles and coinsurance (excluding pharmacy). Out-of-pocket maximums exclude balance billing by out-of-network providers.

Medical Services Costs

Here's a look at your benefits under the San Francisco medical plan.

Medical	San Francisco Medical Plan	
	In-network	Out-of-network
Deductible (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000
Annual Out-of-Pocket Maximum (Individual/Family)	$4,000 / $9,000	$11,000 / $22,000
Preventive Care ■ Annual Physical ■ Well Woman ■ Well Baby/Child ■ Immunizations	Covered 100%	You pay 50% after deductible
Telemedicine	$15 copay	You pay 50% after deductible
Retail Clinics	$30 copay	You pay 50% after deductible
Primary Care Doctor	$30 copay	You pay 50% after deductible
Specialist	$40 copay	You pay 50% after deductible
Urgent Care	You pay 20% after deductible	You pay 50% after deductible
Outpatient Care	You pay 20% after deductible	You pay 50% after deductible
Inpatient Care	You pay 20% after deductible	You pay 50% after deductible
Emergency Care	You pay 20% after deductible	You pay 50% after deductible

What Happens to Your Medical Benefits If:

YOU LEAVE THE COMPANY: Your medical coverage will end on the date your employment with the company ends. Generally, this will be your last day worked. Payroll deductions for your covered child(ren) are not prorated. If your child(ren) are actively enrolled in the medical plan during the pay period, you are responsible for their entire contribution for that pay period. To continue medical benefits, please see the Notice of COBRA Continuation Coverage Rights Under COBRA in the Resources section on **mybbwbenefits.com**.

YOU'RE ON LEAVE OF ABSENCE: Contact Associate Connect to learn about how to continue your medical benefits.

YOU TRANSFER OUT OF SAN FRANCISCO: You are not eligible for the San Francisco medical plan if you work outside the city of San Francisco. Your San Francisco medical benefits end on the date you transfer out of the City of San Francisco.

If you are benefits-eligible, and you are enrolled in the San Francisco medical plan, you will have the opportunity to enroll in a different Bath & Body Works medical plan. If you are benefits-eligible, and you are not enrolled in the San Francisco medical plan, your medical coverage will not change.

If you are non-benefits eligible, you will no longer have medical coverage through Bath & Body Works.

To continue medical benefits, please see the Notice of COBRA Continuation Coverage Rights Under COBRA in the Resources section on **mybbwbenefits.com**.

Contact Associate Connect at 1.866.473.4728 if you have questions about the status of your medical benefits.

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San Francisco Medical Plan Benefits: The Details

Covered Services & Supplies	San Francisco Medical Plan	
	In-network	Out-of-network
Acupuncture (stet)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Allergy ■ Office visit ■ Testing ■ Allergy injections	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Anesthesia Covered as In-Network and subject to Deductible and local Plan pricing when services rendered in a participating facility.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Autism Applied Behavior Analysis (ABA) Therapy (pre-certification required) Autism Case Management and Behavioral Health Services offered at no cost to plan members.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
BEHAVIORAL HEALTH/SUBSTANCE ABUSE CARE		
Hospital inpatient services ■ Inpatient Accommodations and Ancillaries ■ Detox ■ Residential Treatment	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Outpatient services Intensive Outpatient therapy (IOP) and Partial Hospitalization (PHP). Co-Pay applies to visits/consults only. Other services (including IOP and PHP) are subject to Deductible and Coinsurance. Applied Behavioral Analysis (ABA) Therapy is NOT covered.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Doctor's services (Home and Office Visits)	Doctor's Office Covered at 100% after $30 Co-Pay / $40 Specialist Co-Pay Deductible does not apply.	50% Coinsurance after satisfaction of Calendar Year Deductible.
ADD/ADHD Includes Autistic Disease, Mental Retardation, Developmental Delays and Learning Disabilities.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Biofeedback	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Blood Processing and Storage	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Clinical Trials	Clinical trials of any sort are not covered. However, effective 1/1/14, due to Health Care Reform, if you are a part of an FDA approved clinical trial for a life-threatening disease it will be covered under normal medical expenses that occur during the trial (i.e. lab work).	
Ambulance Services (when Medically Necessary) Land/Air	20% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at the In-Network benefit level.
Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical condition manifesting 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 the absence of immediate medical attention to result in one of the following conditions: 1. 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; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount of the Out-of-Network Provider charges.		
EYE CARE		
Medical Vision Exam Office visit – medical eye care exams (treatment of disease or Injury to the eye). Treatment other than office visit. Orthoptic training (eye-muscle exercise) is covered if services are rendered by a licensed Optometrist or an Orthoptic Technician.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Vision Hardware For glasses or contact lenses following cataract surgery, refer to P&O benefit..	Not Covered	

Covered Services & Supplies	San Francisco Medical Plan	
	In-network	Out-of-network
HEARING CARE		
Office visit - Audiometric exam/hearing evaluation test Cochlear Implants. No coverage for hearing loss due to age. Routine hearing exams are not covered under this medical Plan.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Hearing Aid Services Hardware - Hearing Aids including exams and hearing aid fitting, testing and accessories. Limited to 1 hearing exam in a 24-month period payable at 100% after PCP/ Specialist Co-Pay. **Maximum reimbursement is $1,500 per covered person every 24 months.**	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
HOME HEALTH CARE & HOSPICE CARE		
Home Health Care Services Private Duty Nursing is only covered in the Home and visits count toward the Home Health Care visit maximum. **Includes Home Infusion Therapy (services do not count toward the visit maximum).**	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Maximum visits per Calendar Year Maximum 120 visits per Calendar Year – combined In-Network and Out-of-Network.		
Hospice Care Services Bereavement counseling services must be given within six months after the patient's death.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
HOSPITAL INPATIENT SERVICES – PRECERTIFICATION REQUIRED		
Room and Board (Semiprivate or ICU/CCU)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Hospital services and supplies Precertification is required for hospital services.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Inpatient Physical Medical Rehab Limited to 120 days per Calendar Year.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Skilled Nursing Facility Limited to 120 days per Calendar Year..	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Pre-surgical/Pre-admission testing	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Doctor Services ■ Surgeon ■ Anesthesiologist ■ Radiologist ■ Pathologist **Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services at an In-Network facility.** If an Out-of-Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Infusion Therapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
MATERNITY CARE & OTHER REPRODUCTIVE SERVICES		
Doctor's office: Global care (includes pre-and post-natal, delivery): ■ Primary care Doctor (includes obstetrician and gynecologist) ■ Specialist ■ Midwife (Precertification required). ■ Includes Therapeutic and Elective Abortion. ■ Dependent Daughters are covered.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.

Covered Services & Supplies	San Francisco Medical Plan	
	In-network	Out-of-network
MATERNITY CARE & OTHER REPRODUCTIVE SERVICES (CONT)		
Hospital/Birthing Center Services (Precertification required) ■ Doctor's services ■ Newborn nursery services (wellbaby care) ■ Circumcision Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre- certified.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Fertility Services Includes coverage to diagnose and treat infertility; however, a diagnosis of infertility is not required to access fertility treatment services There is a lifetime maximum coverage amount of $20,000 for services and supplies associated with the treatment of Infertility, and a lifetime maximum coverage amount of $10,000 for related pharmacy expenses. Assisted Reproductive Technology (ART) services and supplies specific to ART. (This does not include coverage for infertility treatment services as a result of voluntary sterilization). Fertility Preservation (elective and medically indicated), including egg and sperm freezing with one year of storage beginning from the initial date of cryopreservation	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Infertility Treatment -Artificial Insemination There is a lifetime maximum coverage amount of $20,000 for services and supplies associated with the treatment of infertility, and a lifetime maximum coverage amount of $10,000 for related pharmacy expenses. Limited to usage for one 6-month period in the Covered person's lifetime.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
OUTPATIENT HOSPITAL / FACILITY SERVICES		
Outpatient facility	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Surgery - (Institutional) Includes Ambulatory surgery	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Lab and x-ray services	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Outpatient Doctor services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Consultation, Second Opinion Outpatient/Office/Clinic	**Doctor's Office (PCP)** Covered at 100% after $30 Co-Pay/ $40 Specialist Co-Pay. Deductible does not apply.	50% Coinsurance after satisfaction of Calendar Year Deductible.
DOCTOR SERVICES (HOME AND OFFICE VISITS)		
Doctor or Specialist Visit	**Doctor's Office (PCP)** Covered at 100% after $30 Co-Pay/ $40 Specialist Co-Pay. Deductible does not apply.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Office Surgery	**Doctor's Office (PCP)** Covered at 100% after $30 Co-Pay/ $40 Specialist Co-Pay. Deductible does not apply.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Prescription Injectables/ Prescription Drugs Dispensed in the Doctor's Office	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Preventive Services (regardless of Provider or setting where Preventive care is provided)	Covered at 100% Deductible does not apply.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Retail Health Clinic-Professional Co-Pay applies to professional office visit charge only.		
Skilled Nursing Facility	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Maximum days	120 days per Calendar Year	

Covered Services & Supplies	San Francisco Medical Plan	
	In-network	Out-of-network
SURGICAL SERVICES		
Surgery Cosmetic/Reconstructive Surgery (subject to Medical Necessity)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Gastric Bypass/Obesity Surgery When Medically Necessary Precertification Required	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
THERAPY SERVICES - OUTPATIENT		
Doctor or Specialist office visit	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Outpatient Services	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Physical Therapy (Maximum visits per Calendar Year) Occupational Therapy ■ Combined Institutional/Professional. ■ Maintenance therapy is not covered. ■ Outpatient services subject to Deductible and Coinsurance. Speech Therapy ■ Combined Institutional/Professional. ■ Outpatient services subject to Deductible and Coinsurance.	Doctor's Office Covered at 100% after $30 Co-Pay/ Specialist $40 Co-Pay Deductible does not apply. 30 visit maximum per Calendar Year combined In and Out-of-Network (not combined with any other therapy). Visits beyond 30 require ongoing documentation from your attending Doctor and are limited to maximum medical improvement.	30 visit maximum per Calendar Year combined In and Out-of-Network (not combined with any other therapy). Visits beyond 30 require ongoing documentation from your attending Doctor and are limited to maximum medical improvement.
Chiropractic Care (Maximum visits per Calendar Year)	Doctor's Office Covered at 100%after $30 Co-Pay/ Specialist $40 Co-Pay Deductible doesn't apply. 20 visit maximum per Calendar Year combined In and Out-of-Network (includes all services performed by a chiropractor).	20 visit maximum per Calendar Year combined In and Out-of-Network (includes all services performed by a chiropractor).
Cardiac and Pulmonary Rehabilitation Maintenance therapy is not covered.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Chemotherapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Radiation Therapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Respiratory Therapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Infusion Therapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
Vision Therapy (Outpatient Hospital setting) Orthoptic training (eye-muscle exercise) is covered if services are rendered by a licensed Optometrist or an Orthoptic.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
NOTE: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Transgender Surgery Medically necessary surgical procedures Covered persons must be 18 years or older and meet all eligibility qualifications outlined under the Plan. Services must be performed by a qualified provider at a facility with a history of treating individuals with gender changes. Prior to all treatment, services must be authorized by Anthem. Certain services are not covered.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.

Covered Services & Supplies	San Francisco Medical Plan	
	In-network	Out-of-network
THERAPY SERVICES - OUTPATIENT (CONT)		
Transplants Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, including Medically Necessary preparatory myeloablative therapy. The Center of Excellence requirements do not apply to Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Coverage starts one day prior to a Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.) Note: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)	**Center of Excellence** Covered at 100% **Network Transplant Center** 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered
Covered Transplant Procedure during the Transplant Benefit Period Care coordinated through a Center of Excellence. You are responsible for any charges from the Out-of-Network Transplant Provider.	**Center of Excellence** Covered at 100% **Network Transplant Center** 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient) Includes unrelated donor search up to $30,000 per transplant.	**Center of Excellence** Covered at 100% **Network Transplant Center** 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement) Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	**Center of Excellence** Covered at 100% **Network Transplant Center** 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered
Eligible Travel and Lodging Lodging Allowance: $50 per day for one person; $100 per day for two persons. Reimbursed at 100% as long as transplant is covered and performed at Center of Excellence facility. Travel includes: Transportation for two companions if the patient is a minor child No dollar limit amount per fare. Travel is reimbursed for patient and companion. Facility must be greater than 50 miles from members home. Maximum: $10,000 per transplant.	**Center of Excellence** Covered at 100% **Network Transplant Center** 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered
All Other Covered Transplant Services	**Center of Excellence** Covered at 100% **Network Transplant Center** 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered

Health Care Management – Precertification

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to determine when services should be covered by your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization: Network Providers are required to obtain prior authorization in order for you to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments which are more cost effective.

If you have any questions regarding the information contained in this section, you may call the Customer Service telephone number on your Identification Card or visit www.anthem.com.

Types of Requests

PRECERTIFICATION A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Doctor must notify the Claims Administrator within 2 business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

PREDETERMINATION An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Claims Administrator will review your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

POST SERVICE CLINICAL CLAIMS REVIEW A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

General Exclusions and Limitations

The plan does not cover any expenses incurred for services, supplies, medical are or treatment relating to, arising out of, or given in connection with the following:

SERVICES NOT COVERED BY THE PLAN	ADDITIONAL INFORMATION
Admissions for Non-Inpatient Services	Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
Administrative Charges	Charges for any of the following: ■ Failure to keep a scheduled visit; ■ Completion of claim forms or medical records or reports unless otherwise required by law; ■ For Doctor or Hospital's stand-by services; ■ For holiday or overtime rates. ■ Membership, administrative, or access fees charged by Doctors or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results. ■ Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
Allergy Services	Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections.
Alternative Therapies	Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to recreational, or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.
Before Coverage Begins/ After Coverage Ends	Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends.
Biomicroscopy	Biomicroscopy, field charting or aniseikonic investigation.
Comfort and Convenience Items	Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
Complications	Complications of non-covered procedures are not covered.
Cosmetic Services/Beautification Procedures	Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by the Claims Administrator is not covered. (See sections a. and b. below.) ■ This exclusion does not apply to surgery to restore function if anybody area has been altered by disease, trauma, congenital/ developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries that caused the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. ■ This exclusion does not apply to Breast Reconstructive Surgery. Complications directly related to cosmetic services treatment or surgery, as determined by the Claims Administrator, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded Plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions
Court-Ordered Services	Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.
Crime and Incarceration	Injuries received while committing a crime as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation. This Exclusion does not apply if you were the victim of a crime, including domestic violence.
Custodial Care and Rest Care	Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Doctor. Inpatient Room and Board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain.
Daily Room Charges	Daily room charges while the Plan is paying for an Intensive care, cardiac care, or other special care unit.

SERVICES NOT COVERED BY THE PLAN	ADDITIONAL INFORMATION
Dental Care	Dental care and treatment and Oral Surgery (by Doctors or Dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (Fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or Periodontal Disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this book.
Educational/Behavioral Services	Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems. Special education, including lessons in sign language to instruct a Member, whose ability to speak have been lost or impaired, to function without that ability, is not covered.
Excessive Expenses	Expenses in excess of the Plan's Maximum Allowed Amount.
Employer or Association Medical/Dental Department	Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
Experimental/Investigative Services	Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigative for the diagnosis for which the Member is being treated. An Experimental or Investigative service is not made eligible for coverage by the fact that other treatment is considered by a Member's Doctor to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
Family Members	Services rendered by a Provider who is a close relative or Member of your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
Foot Care	Foot care only to improve comfort or appearance, routine care of corns, calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
Free Services	Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage
Government Programs	Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a Member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
Health Spa	Expenses incurred at a health spa or similar facility.
Ineligible Hospital	Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
Ineligible Provider	Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
Inpatient Rehabilitation Programs	Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a Doctor or: the treatment is for maintenance therapy; or ■ the Member has no restorative potential; or ■ the treatment is for congenital learning or neurological disability/disorder; or ■ the treatment is for communication training, educational training or vocational training.
Maintenance Care	Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.
Marital Counseling	Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
Medicare Benefits	Services paid under Medicare Benefits (in circumstances where Medicare is or would be primary to the Plan) or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD) after the coordination period, Medical Parts A and B shall be treated as the primary payor whether or not the Member has enrolled in Medicare Part B. For services provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
Never Events	The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The Provider will be expected to absorb such costs. This Exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
Non-Covered Services	Any item, service, supply or care not specifically listed as a Covered Service in this book.
Not Medically Necessary Services	Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

SERVICES NOT COVERED BY THE PLAN	ADDITIONAL INFORMATION
Obesity Services	Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss, etc.).
Over the Counter Drug Equivalents	Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over- the-counter products that the Plan must cover under federal law with a Prescription.
Prescription Drugs	Any Prescription Drugs purchased at a retail or Home Delivery (Mail Service) Pharmacy.
Private Duty Nursing	For Private Duty Nursing services except when provided through the “Home Care” benefit.
Private Rooms	Private room, except as specified as Covered Services.
Research Screenings	For examinations related to research screenings, unless required by law.
Reversal of Sterilization	Services related to or performed in conjunction with reverse sterilization.
Routine Examinations	Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms illness or Injury except those which may be specifically listed as covered in this book.
Safe Surroundings	Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
Sclerotherapy	Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with Sclerotherapy.
Services Not Specified as Covered	No Benefits are available for services that are not specifically described as Covered Services in this book. This exclusion applies even if your Doctor orders the service.
Sexual Dysfunction	Medical/ surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or Implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
Shoes	Shoe inserts, (except when prescribed by a Doctor for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
Smoking Cessation	Smoking Cessation programs and treatment of nicotine addiction including gum, patches and Prescription Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products, unless otherwise required by law.
Spider Veins	Treatment of telangiectatic dermal veins (spider veins) by any method.
Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary	Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to: ■ Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards; ■ Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs; ■ The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment; ■ Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers; ■ Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a Member’s house or place of business and adjustments made to vehicles; ■ Air conditioners, humidifiers, dehumidifiers, or purifiers; ■ Rental or purchase of equipment if you are in a facility which provides such equipment; ■ Other items of equipment that the Claims Administrator determines do not meet the listed criteria.
Therapy Services	Services for Outpatient therapy or rehabilitation other than those specifically listed as covered in this book. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.
Transplant Services	The following services and supplies rendered in connection with organ/tissue/bone marrow transplants: Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants; ■ Transportation, travel or lodging expenses for non-donor family Members; ■ Donation related services or supplies, including search, associated with organ acquisition and procurement; ■ Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; any transplant not specifically listed as covered.

SERVICES NOT COVERED BY THE PLAN	ADDITIONAL INFORMATION
Transportation	Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services that are not Medically Necessary. Transportation to another area for medical care is also excluded except as stated as covered under the "Ambulance Service" section. Ambulance transportation from the Hospital to the home is not covered.
Travel Costs and Mileage	For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer.
Thermograms	Thermograms and thermography.
Vision Care	Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in this book. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.
Vision Surgeries	Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
Waived Fees	Any portion of a provider's fee or charge which is ordinarily due from a Member but which has been waived. If a provider routinely waives (does not require the Member to pay) an Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual Provider fee or charge the fee or charge by the amount waived.
War / Military Duty	Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
Workers' Compensation	Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

Medical Plan Individual Case Management

The Claims Administrator's medical plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your medical plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, the Claims Administrator will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Doctor(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service through the Claims Administrator's Case Management program. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator's will make any recommendation of alternate or extended benefits to the Plan on a case-by-case, if in the Claims Administrator's discretion the alternate or extended benefit is in the best interest of the Member and the Plan. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify you or your authorized representative in writing.

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The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official plan documents will govern.