Quality Care Health Plan – Medical Benefits Summary

In-Network Benefit: Preventive services are paid at 100 percent. Unless otherwise indicated, a 85 percent benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60 percent of allowable charges after plan year deductible.

This document contains a brief overview of some of the benefits available under the Quality Care Health Plan (QCHP). Contact the plan administrator for more information or coverage requirements and/or limitations. **In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator. The information below indicates the requirements and benefit levels of the covered services, supplies and therapies for the standard benefit level (60 percent of allowable charges). There is a 85 percent enhanced benefit level for utilizing network providers.**

Acupuncture

- Charges for treatment of diagnosed chronic pain with a written referral from a physician or dentist. Coverage is subject to frequency limitations. **Note:** Chronic pain is defined as pain that persists longer than the amount of time normally expected for healing.

Ambulance (See Exclusion #5 and #40)

- Transportation charges to the nearest hospital/facility for emergency medically necessary services for a patient whose condition warrants such service. The plan administrator should be notified as soon as possible for a determination of coverage. Medically necessary transportation charges (emergency ground or air ambulance) will be paid at the 85 percent benefit level after the annual plan year deductible has been met. Services that are determined not to be medically necessary will not be covered.
- Transportation services eligible for coverage:
  - From the site of the disabling illness, injury, accident or trauma to the nearest hospital qualified to provide treatment (includes air ambulance when medically necessary).
  - From a remote area, by air, land or water (inside or outside the United States), to the nearest hospital qualified to provide emergency medical treatment.
  - From a facility which is not equipped to treat the patient's specific injury, trauma or illness to the nearest hospital equipped to treat the injury, trauma or illness.

Behavioral Health

In an emergency or a life-threatening situation, call 911, or go to the nearest hospital emergency room. Plan participants must call the behavioral health plan administrator within 48 hours to avoid a financial penalty. Authorization requirements still apply when plan participants have other coverage.

- **Inpatient services** must be authorized prior to admission or within 48 hours of an emergency admission to receive in-network or out-of-network benefits. Authorization is required with each new admission. Failure to notify the behavioral health plan administrator of an admission to an inpatient facility within 48 hours could result in a financial penalty and risk incurring non-covered charges.
- **Partial hospitalization and intensive outpatient treatment** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required before beginning each treatment program. Failure to notify the behavioral health plan administrator of a partial hospitalization or intensive outpatient program could result in a financial penalty and risk incurring noncovered charges.
- **Outpatient services** received at the in-network benefit level must be provided by a QCHP network provider. Most routine outpatient services (such as therapy sessions and medication management) will be covered without the need for prior authorization. Authorization requirements for certain specialty outpatient services are noted below. Outpatient services that are not consistent with usual treatment practice for a plan participant's condition will be subject to a medical necessity review. The behavioral health administrator will contact the plan participant's provider to discuss the treatment if a review will be applied. Outpatient services received at the out-of-network benefit level must be provided by a licensed professional including licensed clinical social worker (LCSW), registered nurse, clinical nurse specialist (RN CNS), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), psychologist or psychiatrist to be eligible for coverage.
- **Electroconvulsive therapy, psychological testing and applied behavioral analysis** must be authorized to receive in-network or out-of-network benefits. Failure to obtain authorization will result in the risk of incurring non-covered charges.

- **Residential services** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required with each new residential admission. Failure to notify the behavioral health plan administrator of an admission to a residential facility could result in a financial penalty and risk incurring non-covered charges.

Breast Reconstruction Following Mastectomy

- The plan provides coverage, subject to and consistent with all other plan provisions, for services following a mastectomy, including:
  - Reconstruction of the breast (including implants) on which the mastectomy was performed.
  - Surgery and reconstruction on the other breast (including implants) to produce a symmetrical appearance.
  - Prosthesis and treatment for any physical complications at any stage of mastectomy, including post-surgical lymphedema (swelling associated with the removal of lymph nodes) rendered by a provider covered under the plan.
  - Mastectomy bras are covered following surgery or a change in prosthesis.

Cardiac Rehabilitation

- Phase I and Phase II when ordered by a physician.

Chiropractic Services

- Maximum of thirty (30) visits per plan year will be covered.
- No coverage for chiropractic services considered to be maintenance in nature, in that medical information does not document progress in the improvement of the condition.

Christian Science Practitioner

- Coverage for the services of a Christian Science Nurse or Practitioner.
  - A Christian Science Nurse is a nurse who is listed in a Christian Science Journal at the time services are given and who: (a) has completed nurses' training at a Christian Science Benevolent Association Sanitarium; or (b) is a graduate of another School of Nursing; or (c) had three consecutive years of Christian Science Nursing, including two years of training.
  - A Christian Science Practitioner is an individual who is listed as such in the Christian Science Journal at the time the medical services are provided and who provides appropriate treatment in lieu of treatment by a medical doctor.

Circumcision

- Charges for professional services.
- Charges for circumcision are considered to be covered services when billed as a separate claim for the newborn as long as the newborn is enrolled in the plan and the surgery is performed within the first thirty (30) days following birth.

Dental Services (See Exclusion #14 and # 15)

- **Accidental Injury:**
  - Coverage for professional services necessary as a result of an accidental injury to sound natural teeth caused by an external force. Care must be rendered within three months of original accidental injury. The appropriate facility benefit applies.
- **Nonaccidental:** Coverage limited to:
  - Anesthesia and facility charges for dependent children age six and under.
  - A medical condition that requires anesthesia and facility charges for dental care (not anxiety or behavioral related conditions). Professional services are not covered under the medical plan.

Diabetic Coverage

- Charges for dietitian services and consultation when diagnosed with diabetes. No coverage unless ordered in conjunction with a diagnosis of diabetes.
- Charges for routine foot care by a physician when diagnosed with diabetes.
- Charges for insulin pumps and related supplies when deemed medically necessary.

Dialysis

- Charges for hemodialysis and peritoneal dialysis.

Durable Medical Equipment (DME)

(See Exclusion #5)

- **Short-term Rental:**
  - Rental fees up to the purchase price for items that

temporarily assist an impaired person during recovery. Examples include canes, crutches, walkers, hospital beds and wheelchairs.

- **Purchase:**
  - Charges to purchase the equipment. Equipment should be purchased only if it is expected that the rental costs will exceed the purchase price.
- DME exclusions include, but are not limited to:
  - Repairs or replacements due to negligence or loss of the item.
  - Newer or more efficient models.
- DME is eligible for coverage when provided as the most appropriate and lowest cost alternative as required by the person's condition.

NOTE: See Prosthetic Appliances for permanent replacement of a body part.

Emergency Services

The facility in which emergency treatment is rendered and the level of care determines the benefit level (hospital, urgent care center, physician office). For emergency transportation services, refer to the 'Ambulance' section.

- **Emergency Room:**
  - 85 percent of allowable charges after the special emergency room deductible at a QCHP or non-QCHP facility. The special deductible applies to each visit to an emergency room which does not result in an inpatient admission.
- **Physician's Office:**
  - 85 percent of allowable charges; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. Nonemergency medically necessary care is considered at 60 percent of allowable charges.
- **Urgent Care or Similar Facility:**
  - 85 percent of allowable charges; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. This benefit applies to professional fees only. Facility charges not covered when services are performed in a physician's office or urgent care center. Nonemergency medically necessary care is considered at 60 percent of allowable charges.

Eye Care (See Exclusion #11 and #26)

- Charges for treatment of injury or illness to eye.

Foot Orthotics

Notification is required. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

- Must be custom molded or fit to the foot and ordered by a physician or podiatrist.

Hearing Services

- Diagnostic hearing exams performed by an audiologist are covered up to $150 and hearing aids are covered up to $600 every three plan years.
- Professional service charges for the hearing exam associated with the care and treatment of an injury or an illness.

Hospice

- Written notification of the terminal condition is required from the attending physician.
- Inpatient hospice requires notification. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

Inpatient Hospital/Facility Services

(See Exclusions #3, #6, #8, #32)

- Hospital/facility charges.

QCHP

- In-network - 85 percent of allowable charges after the special deductible at a QCHP facility. The special deductible applies to each hospital stay.
- Out-of-network - 60 percent of allowable charges after the special deductible at a non-QCHP facility. The special deductible applies to each hospital stay.

NOTE: Failure to provide notification of an upcoming admission or surgery will result in a financial penalty and denial of coverage for services not deemed medically necessary. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

Infertility Treatment

Benefits are provided for the diagnosis and treatment of infertility. Infertility is defined as the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with

a condition affecting fertility, or the inability to sustain a successful pregnancy. A woman shall be considered infertile without having to engage in one year of unprotected sexual intercourse if a physician determines that: 1) a medical condition exists that renders conception impossible through unprotected sexual intercourse; or 2) efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

- Predetermination of Benefits:
  - A written predetermination of benefits must be obtained from the health plan administrator prior to beginning infertility treatment to ensure optimum benefits. Documentation required from the physician includes the patient's reproductive history including test results, information pertaining to conservative attempts to achieve pregnancy and the proposed plan of treatment with physicians' current procedural terminology (CPT) codes.
- Infertility Benefits:
  - Coverage is provided only if the plan participant has been unable to sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this plan.
- Coverage for assisted reproductive procedures includes, but is not limited to:
  - Artificial insemination, in vitro fertilization (IVF) and similar procedures which include but are not limited to: gamete intrafallopian tube transfer (GIFT), low tube ovum transfer (LTOT), zygote intrafallopian tube transfer (ZIFT), and uterine embryo lavage with a maximum of four (4) procedures per lifetime;
  - A maximum of three (3) artificial insemination procedures per menstrual cycle for a total of eight (8) cycles per lifetime;
  - A maximum of four (4) procedures per lifetime for any of the following: invitro fertilization, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) and other similar procedures;
  - If a live birth results from an in vitro procedure, two additional procedures are eligible for coverage;
  - Eligible medical costs associated with sperm or egg donation by a person covered under the plan may include, but are not limited to, monitoring the cycle of a donor and retrieval of an egg for the purpose of donating to a covered individual.
- Infertility treatment exclusions include, but are not limited to:
  - Nonmedical expenses of a sperm or egg donor otherwise covered under the plan such as transportation, shipping or mailing, administrative fees such as donor processing, search for a donor or profiling a donor, cost of sperm or egg purchased from a donor bank, cryopreservation and storage of sperm or embryo or fees payable to a donor;
  - Infertility treatment deemed experimental or unproven in nature;
  - Reversal of voluntary sterilization;
  - Payment for medical services rendered to a surrogate for purposes of attempting or achieving pregnancy;
  - Pre-implantation genetic testing.

Lab and Radiology

- Outpatient:
  - Charges at a physician's office, hospital, clinic or urgent care center.
- Inpatient:
  - If billed by a hospital as part of a hospital confinement, paid at the appropriate hospital benefit level.
- Professional charges:
  - Professional charges associated with the interpretation of the lab or radiology procedures.

Medical Supplies (See Exclusions #3, #5, #19)

- Medical supplies include, but are not limited to ostomy supplies, surgical dressings and surgical stockings.

Morbid Obesity Treatment (See Exclusion #12)

- Charges for professional services.
- Obesity surgery is eligible for covered dependents with a showing of medical necessity and predetermination of benefits.

Newborn Care (See Exclusion #39)

- Charges for professional services in an office or hospital setting.
- Benefits are available for newborn care only if the dependent is enrolled no later than 60 days following the birth.

Occupational Therapy/Physical Therapy (See Exclusion #10)

Notification is required. Refer to 'Notification Requirements'

in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

- Covered if administered under the supervision of and billed by a licensed or registered occupational therapist, physical therapist or physician.

Outpatient Hospital/Facility Services, including Surgery

(See Exclusions #3, #4, #6)

- Covered if performed at a hospital/facility.
- Covered if performed at an ambulatory surgical treatment center which is licensed by the Department of Public Health, or the equivalent agency in other states, to perform outpatient surgery.

Physician Services

- Charges for medical treatment of an injury or illness.

Physician Services – Surgical

(See Exclusions #12, #13, #16)

- Inpatient Surgery:
  - Follow-up care by the surgeon is considered part of the cost of the surgical procedure and is NOT covered as a separate charge.
- Outpatient Surgery:
  - If surgery is performed in a physician's office, the following will be considered as part of the fee:
  - Surgical tray and supplies.
  - Local anesthesia administered by the physician.
  - Medically necessary follow-up visits.
- Plastic and reconstructive surgery is limited for the following:
  - An accidental injury.
  - Congenital deformities evident at infancy.
  - Reconstructive mammoplasty following a mastectomy.
- Assistant surgeon:
  - A payable assistant surgeon is a physician who assists the surgeon, subject to medical necessity.
  - Up to 20 percent of allowable charges of eligible charges.
- Multiple surgical procedures:
  - Standard plan guidelines are used in processing claims when multiple surgical procedures are performed during the same operative session.
  - Charges for the most inclusive (comprehensive) procedure. Additional procedures are paid at a lesser level. Contact the plan administrator for a predetermination of benefits.

Podiatry Services (See Exclusion #9)

Notification is required. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

Prescription Drugs

- Drug charges if billed by a physician's office and not obtained at a pharmacy.
- Prescription drugs obtained as part of a skilled care facility stay are payable by the health plan administrator.
- Prescription drugs obtained as part of a hospital stay are payable at the appropriate facility benefit level.
- Prescription drugs billed by a skilled nursing facility, extended care facility or a nursing home must be submitted to the prescription drug plan administrator.

Preventive Services

Routine preventive care services which do NOT require a diagnosis or treatment are covered at 100 percent when utilizing a network provider. Out-of-network preventive care is covered at the out-of-network benefit level. Your doctor will determine the tests and frequency that are right for you based on your age, gender and family history. In-network preventive services are not subject to the plan year deductible.

NOTE: **Claims which indicate a diagnosis are not considered preventive and are subject to the plan year deductible and coinsurance.**

Prosthetic Appliances

A prosthetic appliance is one which replaces a body part. Examples are artificial limbs and artificial eyes.

- Charges for:
  - The original prosthetic appliance.
  - Replacement of a prosthetic appliance due to growth or a change in the person's medical condition.
  - Repair of a prosthetic appliance due to normal wear and usage rendering the appliance no longer functional.
- No payment will be made if the appliance is damaged or lost due to negligence.

- Prosthetic appliances exclusions include, but are not limited to:
  - Appliances not recommended or approved by a physician.
  - Appliances to overcome sexual dysfunction, except when the dysfunction is related to an injury or illness.
  - Items considered cosmetic in nature such as artificial fingernails, toenails, eyelashes, wigs, toupees or breast implants.
  - Experimental or investigational appliances.

Skilled Nursing Service – Home Setting

- Contact the Notification/Medical Case Management plan administrator for a determination of benefits.
- The benefit for skilled nursing service will be limited to the lesser of the cost for care in a home setting or the average cost in a skilled nursing facility, extended care facility or nursing home within the same geographic region.
- The continued coverage for skilled nursing service will be determined by the review of medical records and nursing notes.

Skilled Nursing – In a Skilled Nursing Facility, Extended Care Facility or Nursing Home

(See Exclusions #3, #4, #6)

- Benefits are subject to skilled care criteria and will be allowed for the most cost-effective setting or the level of care required as determined by the Notification/Medical Case Management plan administrator.
- Must be a licensed healthcare facility primarily engaged in providing skilled care.
- Notification is required at least seven days prior to admission or at time of transfer from an inpatient hospital stay.
- Benefits are limited to the average cost of available facilities within the same geographic region.
- The service must be medically necessary.
- The continued coverage for skilled nursing service will be determined by the review of medical records and nursing notes.
- Prescription drug charges must be submitted to the health plan administrator.

NOTE: Extended care facilities are sometimes referred to as nursing homes. Most care in nursing homes is NOT skilled care and therefore is NOT covered. Many people purchase long-term care insurance policies to cover those nursing home services which are NOT covered by medical insurance or Medicare.

Speech Therapy

Notification is required. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

- Charges for medically necessary speech therapy ordered by a physician.
- Treatment must be for a speech disorder resulting from injury or illness serious enough to significantly interfere with the ability to communicate at the appropriate age level.
- The therapy must be restorative in nature with the ability to improve communication.
- The person must have the potential for communication.

Transplant Services

In order for any organ, tissue or bone marrow transplant to be covered under the plan, one of the designated procedure specific transplant hospitals must be utilized. The transplant candidate must contact the Medical Case Management plan administrator of the potential transplant. Once notification occurs, the Medical Case Manager (MCM) will coordinate all treatments and further notification is not required. Those refusing to participate in the MCM program will be notified that coverage may be terminated under the plan for treatment of the condition.

The transplant benefit includes all diagnostic treatment and related services necessary to assess and evaluate the transplant candidate. All related transplant charges submitted by the transplant hospital are covered at 85 percent of the contracted rate.

In some cases, transplants may be considered nonviable for some candidates, as determined by the MCM plan administrator in coordination with the transplant hospital.

- Transplant exclusions include, but are not limited to:
  - Investigational drugs, devices or experimental procedures.
  - Charges related to the search for an unrelated bone marrow donor.
  - A corneal transplant is not part of the transplant hospital benefit; however, standard benefits apply under the medical portion of the coverage.

Transplant Coordination of Donor/Recipient Benefits

- When both the donor and the recipient are covered under the plan, both are entitled to benefits under the plan, under separate claims.
- When only the recipient is covered, the donor's charges are covered as part of the recipient's claim if the donor does not have insurance coverage, or if the donor's insurance denies coverage for medical expenses incurred.
- When only the recipient is covered and the donor's insurance provides coverage, the plan will coordinate with the donor's plan.
- When only the donor is covered, only the donor's charges will be covered under the plan.
- When both donor and recipient are members of the same family and are both covered by the plan, no deductible or coinsurance shall apply.

The transplant hospital network is subject to change throughout the year. Call the Notification/Medical Case Management plan administrator for current transplant hospitals.

Transplant – Transportation/Lodging Benefit

- The maximum expense reimbursement is $2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to $70. There is no reimbursement for meals.
- The plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those plan participants who have been accepted as a candidate for transplant services.
- Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to:

  Organ Transplant Reimbursement
  DCMS Group Insurance Division
  801 S. 7th Street
  P.O. Box 19208
  Springfield, IL 62794-9208

- The plan participant has twelve months from the date expenses were incurred to submit eligible charges for reimbursement. Requests submitted after the twelve-month limit will not be considered for reimbursement.

Urgent Care Services

Urgent care is care for an unexpected illness or injury that requires prompt attention, but is less serious than emergency care. Treatment may be rendered in facilities such as a physician's office, urgent care facility or prompt care facility. This benefit applies to professional fees only. If a facility fee is billed, the emergency room deductible applies.

NOTE: **See Emergency Services for medically necessary emergency care.**

Quality Care Health Plan (QCHP) Exclusions and Limitations

No benefits are available:

1. For services or care not recommended, approved and provided by a person who is licensed under the Illinois Medical Practices Act or other similar laws of Illinois, other states, countries or by a nurse midwife who has completed an organized program of study recognized by the American College of Nurse Midwives or by a Christian Science Practitioner.

2. For services and supplies not related to the care and treatment of an injury or illness, unless specifically stated in this document to be a covered service in effect at the time the service was rendered. Excluded services and supplies include, but are not limited to: sports-related health checkups, employer-required checkups, wigs and hairpieces.

3. For care, treatment, services or supplies which are not medically necessary for the diagnosed injury or illness, or for any charges for care, treatment, services or supplies which are deemed unreasonable by the plan.

4. For charges for the services, room and board or supplies that exceed allowable charges.

5. For personal convenience items, including but not limited to: telephone charges, television rental, guest meals, wheelchair/van lifts, nonhospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps, transportation services or any other services or items determined by the plan to be for personal convenience.

6. For rest, convalescence, custodial care or education, institutional or in-home nursing services which are provided for a person due to age, mental or physical condition mainly to aid the person in daily living such as home delivered meals, child care, transportation or homemaker services.

7. For extended care and/or hospital room and board charges for days when the bed has not been occupied by the covered person (holding charges).

8. For private room charges which are not medically necessary as determined by the plan administrator.

9. For routine foot care, including removal in whole or in part of corns, calluses, hyperplasia, hypertrophy and the cutting, trimming or partial removal of toenails, except for patients with the diagnosis of diabetes.

10. For chiropractic services, occupational therapy and physical therapy considered to be maintenance in nature, in that medical documentation indicates that maximum medical improvement has been achieved.

11. For keratotomy or other refractive surgeries.

12. For the diagnosis or treatment of obesity, except services for morbid obesity, as approved by the plan administrator.

13. For sexual dysfunction, except when related to an injury or illness.

14. For services relating to the diagnosis, treatment, or appliance for temporomandibular joint disorders or syndromes (TMJ), myofunctional disorders or other orthodontic therapy.

15. For an internal accidental injury to the mouth caused by biting on a foreign object and outpatient services for routine dental care.

16. For the expense of obtaining an abortion, induced miscarriage or induced premature birth, unless it is a physician's opinion that such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except in an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the woman or her unborn child.

17. For cosmetic surgery or therapies, except for the repair of accidental injury, for congenital deformities evident in infancy or for reconstructive mammoplasty after partial or total mastectomy when medically indicated.

18. For services rendered by a healthcare provider specializing in behavioral health services who is a candidate in training.

19. For services and supplies which do not meet accepted standards of medical or dental practice at the time the services are rendered.

20. For treatment or services which are investigational, experimental or unproven in nature including, but not limited to, procedures and/or services: which are performed in special settings for research purposes or in a controlled environment; which are being studied for safety, efficacy and effectiveness; which are awaiting endorsement by the appropriate national medical specialty organization; which medical literature does not accept as a reasonable alternative to existing treatments; or, that do not yet meet medical standards of care.

21. For services due to bodily injury or illness arising out of or in the course of a plan participant's employment, which is compensable under any Workers' Compensation or Occupational Disease Act or law.

22. For court mandated services if not a covered service under this plan or not considered to be medically necessary by the appropriate plan administrator.

23. For services or supplies for which a charge would not have been made in the absence of coverage or for services or supplies for which a plan participant is not required to pay.

24. For services arising out of war or an act of war, declared or undeclared, or from participation in a riot, or incurred during or as a result of a plan participant's commission or attempted commission of a felony.

25. For services related to the reversal of sterilization.

26. For lenses (eye glasses or removable contact lenses) except initial pair following cataract surgery.

27. For expenses associated with obtaining, copying or completing any medical or dental reports/records.

28. For services rendered while confined within any federal hospital, except for charges a covered person is legally required to pay, without regard to existing coverage.

29. For charges imposed by immediate relatives of the patient or members of the plan participant's household as defined by the Centers for Medicare and Medicaid Services.

30. For services rendered prior to the effective date of coverage under the plan or subsequent to the date coverage is terminated.

31. For private duty nursing, skilled or unskilled, in a hospital or facility where nursing services are normally provided by staff.

32. For services or care provided by an employer-sponsored health clinic or program.

33. For travel time and related expenses required by a provider.

34. For facility charges when services are performed in a physician's office.

35. For the treatment of educational disorders relating to learning, motor skills, communication and pervasive development conditions.

36. For nonmedical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neuro feedback, hypnosis, sleep therapy, employment counseling, back-to-school, return to work services, work hardening programs, driving safety and services, training, educational therapy or nonmedical ancillary services for learning disabilities, developmental delays, autism (except as provided under covered expenses) or intellectual disability.

37. Wilderness programs and/or therapeutic boarding schools that are not licensed as residential treatment centers.

38. For expenses associated with legal fees.

39. For medical and hospital care and cost for the infant child of a dependent, unless this infant is otherwise eligible under the plan.

40. For transportation between healthcare facilities because of patient's choice; transportation of patients who have no other available means of transportation; transportation that is not medically necessary; or Medicar or similar type of transportation when used for patient's convenience.